

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 waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

A. The State of Pennsylvania requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

Community HealthChoices

C. Waiver Number: PA.0386

Original Base Waiver Number: PA.0386.

D. Amendment Number: PA.0386.R04.12

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

04/01/23

Approved Effective Date: 04/01/23

Approved Effective Date of Waiver being Amended: 01/01/20

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of the amendment is to make the following substantive and technical changes:

- Amend the Benefits Counseling service definition to remove the level of detail about the processes for OVR and the order of selection.

- Modify Service Coordinator and Service Coordinator Supervisor qualifications to align with the CHC Agreement.

- In response to the CARES Act amendment to sections 1814(a) and 1835(a) of the Social Security Act, nurse practitioners and physician assistants, in addition to physicians, may prescribe and order the following services: Home Health Aide Services, Nursing Services, Occupational Therapy Services, Physical Therapy Services and Speech and Language Therapy Services

The state assures with these changes:

- Do not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
- Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	1-G, 2, 6-I
Appendix A Waiver Administration and Operation	
Appendix B Participant Access and Eligibility	
Appendix C Participant Services	C-1-c, C-1/C-3
Appendix D Participant Centered Service Planning and Delivery	D-1-a, D-1-e
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	
Appendix H	
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify:

Modify Service Coordinator and Service Coordinator Supervisor qualifications.

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):

Community HealthChoices

C. Type of Request: amendment

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

3 years 5 years

Original Base Waiver Number: PA.0386

Waiver Number: PA.0386.R04.12

Draft ID: PA.023.04.06

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/20

Approved Effective Date of Waiver being Amended: 01/01/20

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 in 42 CFR §440.160**Nursing Facility**

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable**Applicable**

Check the applicable authority or authorities:

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

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

The Commonwealth operates this §1915(c) waiver application concurrently with a §1915(b) waiver application to implement Community HealthChoices (CHC). The CHC 1915(b) waiver was approved by CMS for the time period of January 1, 2023 through December 31, 2027. CHC is Pennsylvania's managed long-term services and supports initiative. The 1915(b)/1915(c) concurrent waivers allow the Commonwealth to require Medicaid beneficiaries to receive nursing facility, hospice, home and community-based services (HCBS), behavioral health, and physical health services through managed care organizations (MCOs) selected by the state through a competitive procurement process.

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 Eligibility 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.

The Commonwealth of Pennsylvania operates this §1915(c) waiver application concurrently with a §1915(b) waiver application to implement Community HealthChoices (CHC). CHC is Pennsylvania's managed Long-Term Services and Supports (LTSS) initiative. The 1915(b)/1915(c) waivers allow the Commonwealth to require Medicaid beneficiaries to receive both LTSS, including nursing facility, hospice, home and community-based services (HCBS), and physical health services through managed care organizations (MCOs). The MCOs were selected by the state through a competitive procurement process.

The CHC program serves the following:

- Individuals who are 21 years of age or older and who are financially and clinically eligible to receive Medicaid LTSS (whether in the community or in a nursing facilities).
- Individuals who are 21 years of age or older and who are fully eligible for both Medicaid and Medicare, regardless of whether they need or receive LTSS (referred to as "Dual Eligibles") excluding participants who are enrolled in the OBRA waiver or a home and community-based waiver administered by the Office of Developmental Programs.

The CHC 1915(c) waiver will serve individuals who are 21 years of age or older and who are financially and clinically eligible to receive Medicaid LTSS in the community.

CHC operates across 5 geographical zones that comprise all 67 counties. CHC will be the sole Medicaid option for full Dual Eligibles. Other nursing facility clinically-eligible consumers residing in these five zones will have the choice between CHC and the Living Independence for the Elderly (LIFE) program.

CHC serves an estimated 450,000 individuals. CHC-MCOs are accountable for most Medicaid-covered services, including preventive services, primary and acute care, LTSS (HCBS and nursing facilities), prescription drugs, and dental services. Dual Eligibles have the option to have their Medicaid and Medicare services coordinated by the same MCO.

Behavioral Health Services are excluded from CHC-MCO Covered Services. The CHC-MCO must coordinate with the HealthChoices behavioral health MCOs.

Individuals served in the CHC waiver will receive any required behavioral health services (including drug and alcohol services) from behavioral health MCOs in Pennsylvania's other 1915(b) waiver, HealthChoices. The HealthChoices waiver (designated as PA-67) was renewed for a five-year time period beginning January 1, 2022. As renewed, the HealthChoices waiver includes additional populations to accommodate individuals who participate in CHC and who need behavioral health services.

The CHC waiver is administered by the Pennsylvania Department of Human Services (DHS), Office of Long-Term Living (OLTL), an office within the Single State Medicaid Agency. OLTL contracts with the CHC-MCOs to provide services and to enforce waiver obligations. The CHC-MCOs are paid a monthly capitation rate for services. CHC-MCOs may use written contracts meeting the requirements of 42 CFR 434.6 to deliver other services. Entities or individuals under contract or subcontract with the CHC-MCO must meet provider standards described elsewhere in the waiver application.

CHC emphasizes deinstitutionalization and provides an array of services and supports in community-integrated settings.

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. Statewide. Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

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

Geographic Limitation. A waiver of statewide requirements 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 statewide requirements 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 inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

The Office of Long-Term Living (OLTL), in accordance with the public input provisions found at 42 C.F.R. §441.304 (f)(1) – (f)(3) of the Home and Community-Based Services (HCBS) regulations, conducted a public input process to obtain stakeholder input on the CHC waiver amendment.

The following steps were undertaken to seek input on the CHC waiver amendment from stakeholders:

- October 4, 2022, discussed at the Managed Long-Term Services and Supports (MLTSS) Subcommittee of the Medical Assistance Advisory Committee (MAAC).
- October 11, 2022, discussed at the Long-Term Service and Supports (LTSS) Subcommittee of the MAAC.
- November 12, 2022, published Public Notice in the Pennsylvania Bulletin
- November 16, 2022, distributed via the OLTL ListServ and posted to the OLTL website:
<https://www.dhs.pa.gov/contact/DHS-Offices/Pages/OLTL-Waiver-Amendments-and-Renewals.aspx>
- December 14, 2022, public comment period ended.

Participant Involvement in the MAAC Subcommittees – A MLTSS advisory committee was established as a subcommittee of the MAAC. The MLTSS SubMAAC is composed of more than 50% recipients of services in OLTL programs. The subcommittee acts as an advisory body to the Department on CHC and has met monthly since August 2015. OLTL also utilizes the LTSS Subcommittee of the MAAC and has kept its members apprised and sought input from them. The proposed changes to the CHC amendment were presented to the MLTSS SubMAAC on October 4, 2022, and to the LTSS SubMAAC on October 11, 2022. OLTL documented comments from committee members and other stakeholders in attendance at the meetings. Those in attendance had the opportunity to provide comments on the proposed amendment.

Both the MLTSS and the LTSS Subcommittees of the MAAC include participant representation, as well as advocacy representation. All members of these committees are responsible for reaching out to their constituencies to make them aware of the information that is presented at the meetings as well as soliciting their input when asked to review and provide feedback on documents. These committees are used as venues to seek participant and advocate input. Additionally, Service Coordination Entities are asked to share information with all OLTL waiver participants.

Waiver Amendment Public Notice – The required public notice was conducted for the proposed CHC waiver amendment as follows:

- On November 16, 2022, OLTL distributed a notification announcing the availability of the amendment documents via the OLTL ListServ, an email update service. Copies of the amendment revisions were posted on the OLTL website at <https://www.dhs.pa.gov/contact/DHS-Offices/Pages/OLTL-Waiver-Amendments-and-Renewals.aspx>

A Public Notice was published in the Pennsylvania Bulletin on November 12, 2022, which is distributed electronically and in paper format via subscription. The official public comment period ended on December 14, 2022.

Tribal consultation is not required as there are no federally-recognized Tribal Governments in the Commonwealth.

Summary - OLTL made public comment opportunities available via written and mailed submissions, a dedicated email address, provision of direct feedback to OLTL staff, or verbally at the SubMAAC meetings. Clarifying questions were asked and were responded to. Written feedback was received from advocates/advocacy organizations. Feedback was carefully considered and incorporated as appropriate following the public comment period in this submission of the waiver amendment.

A summary of the comments and recommendations received, and the changes made to the application based upon those comments and recommendations, are as follows:

Comment: One commenter requested that home health care clinical services provided by a home health agency enrolled with an MCO be omitted from the CHC Electronic Visit Verification (EVV) requirements.

Response: Thank you for the comment. EVV for home health care services is a Federal requirement and Pennsylvania cannot exempt providers from this requirement.

Comment: Six commenters agreed with nurse practitioners and physician's assistants being able to prescribe, order and reauthorize services.

Response: Thank you for the comments.

Comment: One commenter was concerned that the language added to the waiver that suggests that nurse practitioners and physician assistants may prescribe the referenced services with the independence of physicians. However, this could be interpreted as exceeding their professional authority under the respective practice act since state law governs prescribing authority of nurses and physician assistants.

Response: Thank you for the comment. This change was made to be consistent with Federal law and the PA Medicaid State Plan.

Comment: Three commenters support the service definition changes as proposed to the Benefits Counseling services. By updating the service definition as proposed, DHS is taking steps to remove significant barriers to accessing services that can help members increase employment and other activities in support of their person-centered plan goals.

Response: Thank you for the comments.

Comment: Two commenters requested future consideration be given to modifying the waiver to provide for mileage reimbursement and PAS rates at the same time when an agency care worker drives more than 30 miles, similar to other waivers.

Response: Thank you for the comments. OLTL has explored this option however CMS requirements do not allow for reimbursement of PAS and transportation at the same time. This requirement is specific to the Federal service description OLTL uses in its waivers. Other DHS waivers may use different Federal service descriptions that allow for this.

***Continued in Main Module, Optional ***

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:

Hale

First Name:

Jennifer

Title:

Policy Director

Agency:

Department of Human Services, Office of Long-Term Living

Address:

555 Walnut Street

Address 2:

6th Floor, Forum Place

City:

Harrisburg

State: Pennsylvania

Zip:

17101

Phone:

(717) 346-0495

Ext:

TTY

Fax:

(717) 265-7698

E-mail:

jehale@pa.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Pennsylvania

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Pennsylvania**

Zip:

Phone: Ext: TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

*** Continued from Main Module 6-I - Public Input ***

Comment: Four commenters, referring to criminal background checks, child abuse clearances and provisional hiring, stated that the rules relating to criminal background checks should be the same for consumer-directed and agency provided PAS services. The commenters cited the Pennsylvania's Child Protective Services Law (CPSL) that does not specifically apply to agencies providing personal assistance services under the CHC waiver. Also citing OAPSA which permits provisional hiring.

Response: Thank you for the comments. The criminal background check requirements are the same for consumer-directed services. The clearances are performed by the F/EA. OLTL requires a child abuse clearance for any provider who enters a home where children reside for the protection of those children.

Comment: Four commenters stated that OLTL should add performance measures to monitor disparities in access and quality of services/care to ensure equity within the program.

Response: Thank you for the comments. OLTL agrees with the need to implement this type of measurement; however, it will not be added as a performance measure. Instead, this is being looked at broadly across the entire Department of Human Services as a Department-wide initiative.

Comment: Three comments were received on Service Coordinator qualifications. One commenter stated that while they support the decision to remove the practicum requirement for service coordinators, they would encourage OLTL to further reconsider requirements for service coordinators, and in an effort to bring more people into the workforce. They also encourage OLTL to ensure that service coordinators are appropriately trained to increase retention in this crucial service. Another commenter requested that a high school diploma or GED equivalent should be added for Service Coordinator qualifications and requested practicum experience be kept in the requirements as this type of experience ensures providers will have quality providers of service. The third commenter stated that given the ongoing difficulty with the challenges with Service Coordinator performance, a minimum requirement of qualifications should be implemented. Inserting a requirement for a certain number of trainings related to the disability and individuals they support should be considered.

Response: Thank you for the comments. OLTL agrees and will continue to evaluate Service Coordinator qualifications and trainings.

*** Continued from Appendix A-3. Use of Contracted Entities. ***

The EQRO will provide services consistent with federal law and policy, including EQR protocols published by CMS. The EQRO conducts a series of external quality review activities involving MCOs providing long-term services and supports, physical health services, and behavioral health services, as well as Medicare providers, and assists the state in ensuring coordination of care. The EQRO will also provide an annual report on the analysis and evaluation of aggregated information on quality, timeliness, and access to LTSS and other services provided by MCOs in CHC. The EQRO will validate performance measures, performance improvement projects, and conduct desk audits to determine CHC-MCO compliance with federal and state CHC-MCO quality standards. Part of the EQRO's requirements is to conduct on-site audits if desk audits or other activities indicate a need for more information or validation on performance measures. The EQRO will produce technical reports to OLTL on mandatory activities and will be required to submit ad hoc reports on a weekly, monthly quarterly and annual basis. The annual report is designed to comply with federal requirements; the interim reports will respond to state requirements for early implementation performance.

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

*** Continued from Appendix C-1-c. Delivery of Case Management Services. ***

- 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.
- 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 service plan.
- 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.

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.

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. Essential functions necessary for completion of a successful transition include at a minimum:

- Acting as a liaison between the facility where the participant will be transitioning from and the Independent Enrollment Entity for waiver services
- Performing a comprehensive assessment of the services needed to transition from an institution to the community, while assuring the participant's health and welfare. The comprehensive assessment gathers information about the need for health services, social supports, housing, transportation, financial resources and other needs.
- Providing information to the individual about community resources and assisting the individual, family, Nursing Facility staff and others to ensure timely and coordinated access to Medicaid services, behavioral health services, financial counseling and other services to meet needs.
- Providing housing pre-tenancy and transition services that prepare and support the participant's move to supportive housing in a community integrated setting. Functions include but are not limited to:
 - o Conducting a housing assessment, including a comprehensive budget plan, to determine the participant's housing needs and preferences as well as identifying potential barriers to transition.
 - o Developing an assessment-based housing support plan that identifies the housing services and supports required and will provide the participant with the opportunity to have an informed choice of living options.
 - o Developing a crisis plan that identifies emergent situations that could jeopardize housing and the appropriate interventions.
 - o Assisting with finding and securing housing, completing housing applications, and working with private landlords, housing authorities, Regional Housing Coordinators or other housing entities.

- o Assessing home adaptation needs. Acting as a liaison between contractors and physical or occupational therapists.
- o Assisting, or acting on the behalf of, the participant to obtain needed documentation (e.g., social security card, birth certificate, prior rental history), or resources with Social Security, social services, or community agencies.
- o Conducting or facilitating a housing inspection to ensure unit readiness for occupancy.
- o Coordinating the participant's move to the community and educating the individual on how to retain housing.
- o Providing tenancy sustaining services to assist the participant to retain housing and integrate into the community, foster independence and assist in developing community resources to support successful tenancy and maintain residency in the community. Functions include but are not limited to:
 - o Assisting or coordinating training to develop or restore skills on being a good tenant and/or neighbor and accessing community resources.
 - o Assisting or coordinating training with necessary life skills such as budgeting and routine home maintenance.
 - o Assisting the participant to manage and reduce behaviors that may jeopardize housing.
 - o Assisting the participant to manage their household and understand the terms of a lease or mortgage agreement.
 - o Monitoring and updating the participant's housing support plan as requisite housing skills change.

The following activities are excluded from Service Coordination:

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

Service Coordination must be conflict free and may only be provided by agencies and individuals employed by agencies who are not:

- Related by blood or marriage to the participant or to any paid service provider of the participant.
- Financially or legally responsible for the participant.
- Empowered to make financial or health-related decisions on behalf of the participant.
- Sharing any financial or controlling interest in any entity that is paid to provide care for or conduct other activities on behalf of the participant.
- Individuals employed by agencies paid to render direct or indirect services (as defined by the Department) to the participant, or an employee of an agency that is paid to render direct or indirect services to the participant.

CHC-MCOs must develop, submit for DHS approval, and implement a plan to monitor the performance of Service Coordinators.

Every Participant who has a PCSP developed must have a Service Coordinator assigned to implement and coordinate the services called for in the PCSP.

Service Coordinators and Service Coordinator supervisors must meet the following qualifications:

Service Coordinators must:

- Be a registered nurse (RN) or have a Bachelor's degree in social work, psychology or other related fields, or in lieu of a Bachelor's degree, have at least three (3) or more years of experience in a social service or health care related setting. Service Coordinators hired prior to the CHC zone Implementation Date must have the qualifications and standards proposed by the CHC-MCOs and approved by the department;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52 except those excluded in the CHC Agreement;
- 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 Coordinator supervisors must:

- Be an RN or have a Master's degree in a social work or in a human services or healthcare field and three (3) years of relevant experience with a commitment to obtain either a Pennsylvania social work or mental health professional license within one year of hire. Service Coordinator supervisors hired prior to the CHC zone Implementation Date (who do not have a license) must either: 1) obtain a license within their first year under the new CHC contract in their zone or 2) have the qualifications and standards proposed by the CHC-MCOs and approved by the department;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52 except those excluded in the CHC Agreement;
- 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 Entities under contract with the CHC MCO must:

- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52 except those excluded in the CHC Agreement;
- 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 Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance; and
- Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.

*** Continued from Appendix G, Quality Improvement ***

HW-5: trend analysis were addressed by the CHC-MCO. Denominator: Total number of incidents for CHC waiver participants with reported incidents within the past 12 months where a trend analysis was performed.

HW-10: meet the Healthcare Effectiveness Data and Information Set (HEDIS) eligibility specifications and have Medicaid only or Medicaid and Medicare benefits with the same MCO.

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been

identified as the Single State Medicaid Agency.

Office of Long-Term Living

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The CHC waiver is administered by the Pennsylvania Department of Human Services (DHS), Office of Long-Term Living (OLTL), an office within the Single State Medicaid Agency. OLTL exercises administrative discretion in the administration and is responsible for oversight of the waiver, as well as all policies, procedures and regulations.

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

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

The following details waiver-related organizational responsibilities within OLTL:

- The Bureau of Coordinated and Integrated Services (BCIS) is responsible for the administration and oversight of the Community Health Choices (CHC) Managed Care Organizations (MCO) and the Living Independently for the Elderly (LIFE) managed care program, known nationally as the Program for All-Inclusive Care for the Elderly, which provide managed long-term services and supports to eligible recipients. The bureau negotiates agreements with managed care organizations and contracts with other vendors that support bureau functions; monitors CHC MCO agreements through the readiness review monitoring process; recommends program sanctions and penalties, where appropriate; and directs corrective action plans for CHC MCOs and other contractors. The BCIS also manages the enrollment contracts, including participant outreach, assessment, and the independent enrollment broker (IEB).
- The Bureau of Policy Development and Communications Management (BPDCM) supports the strategic policy and communication goals across all bureaus and the Deputy Secretary's Office. The BPDCM plans, coordinates, evaluates, and develops policies and procedures across the OLTL, and coordinates internal and external communication with stakeholders. The bureau serves as a liaison with other DHS programs and policy offices and other commonwealth agencies, supports all bureaus in the development of consistent policy, evaluating impact, and improving strategic direction. The bureau responds to all right to know requests, develops and processes new regulations, and submits state plan and waiver documents to the federal government.
- The Bureau of Fee for Service Programs (BFFSP) manages provider focused activities and functions in OLTL. The BFFSP coordinates all provider enrollment activities. The BFFSP provides programmatic guidance to service providers and general training and technical support for the bureau, OLTL, business partners and contracted staff. The bureau ensures compliance with federal regulations related to the HCB Settings Rule in coordination with the Quality Management Efficiency Teams (QMETs) that conduct reviews of enrolled providers.
- The Bureau of Quality Assurance and Program Analytics (BQAPA) is responsible for ensuring that valid statistical and procedural methodologies are used to collect and analyze quality control data to evaluate and improve service delivery. The bureau manages data analysis to measure the effectiveness of program design and operations, and ensures required reports are provided to CMS and other regulatory entities. The bureau also supports OLTL management in the development and implementation of policies and procedures, oversees the analysis of data obtained through consumer satisfaction surveys and provider performance measures, and directs all activities related to incident management and risk reduction.
- Bureau of Finance (BOF) manages and monitors OLTLs appropriations and operating budget. The BOF serves as liaison to the DHS budget office and the Governor's budget office. The bureau develops and manages

related fiscal activities including rate setting, cost reporting, budget reporting and submissions, audits, and fiscal management of grants and contracts.

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.:*

Enrollment:

OLTL currently contracts with one non-governmental Independent Enrollment Broker (IEB) entity to facilitate eligibility determinations (waiver related enrollment activities), excluding initial clinical eligibility determinations, for multiple home and community-based waivers managed by OLTL. OLTL will be extending the contract with this entity to perform the same functions for the CHC waiver. Specifically, the Independent Enrollment Broker (IEB) is responsible for the following activities:

- Educate individuals on their rights and responsibilities in long-term services and supports, opportunities for self-direction, appeal rights, and provider choices within the CHC-MCO network;
- Provide applicants with choice of receiving Nursing Facility institutional services; home and community-based waiver services; services through the Living Independence for the Elderly (LIFE) program for individuals aged 55 and over; or no services, and electronically document the applicant's choice;
- Respond to questions about CHC announcement and plan assignment/selection letters;
- Respond to questions about how CHC enrollment and benefits interrelate with Medicare coverage, and refer applicants to the State Health Insurance Assistance Program (APPRISE) as necessary;
- Provide applicants with a choice of Managed Care Organizations and document the individual's choice on the OLTL Service Provider Choice Form;
- Assist the applicant to obtain a completed physician certification form (MA-570) from the individual's physician;
- Refer the applicant to the independent assessment entity for the Clinical Eligibility Determination;
- Assist the participant to complete the financial eligibility determination paperwork; and
- Facilitate the transfer of the new enrollee to their selected Managed Care Organization, including sending copies of all completed assessments and forms.

Initial and Annual Level of Care Determinations:

OLTL has entered into a sole-source contract with a non-governmental independent assessment entity to conduct the initial and annual level of care determinations and redeterminations, hereafter referred to as Functional Eligibility Determinations/Redeterminations. The independent assessment entity performs the Functional Eligibility Determinations and annual Redeterminations, and ensures that Functional Eligibility Determinations are completed 10 days after the participant referral from the Independent Enrollment Broker. The selected entity is also responsible for validating the results of the documentation collected by the CHC-MCO and officially making the annual Functional Eligibility Redetermination. Lastly, the selected entity is responsible for ensuring that Functional Eligibility Determinations and annual Redeterminations are completed within the required timeframes as set forth in policy.

Managed Care Organizations:

OLTL has entered into agreements with fully capitated risk based managed care organizations to conduct operational, administrative, case management and financial management services functions within five regions of the commonwealth for the waiver. CHC-MCOs are also responsible for the following functions: referring individuals to the Independent Enrollment Broker for enrollment; certifying and training direct service providers participating in their provider networks; collecting the documentation and information necessary for completing the annual level of care redetermination and forwarding this information to the independent assessment entity (see above); ensuring that assessments are completed within the required timeframes as set forth in the agreement; ensuring each participant's Person-Centered Service Plan (PCSP) reflects waiver services in the amount, scope, and duration necessary to meet the participant's assessed needs; conducting prior authorization and utilization management of waiver services; conducting ongoing monitoring of contracted providers; and performing quality assurance and quality improvement activities. OLTL allows the CHC-MCOs to use a broker for Home Adaptations, Pest Eradication and Non-Medical Transportation services.

External Quality Review Organization:

Finally, the Department of Human Services has also contracted with an External Quality Review Organization (EQRO). The EQRO is responsible for evaluating the care provided to participants by managed care plans in the areas of quality, access and timeliness. The EQRO provides reports that will help OLTL assess plan results in required quality improvement and performance measurement activities and help both OLTL and the CHC-MCOs understand where resources should be focused to further improve the quality of care.

*** Continued in Main Module - Optional ***

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:

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:

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:

The following bureaus will be responsible for monitoring and assessing the on-going performance of the contracted entities noted in Appendix A-3 and A-4 above. All bureaus operate within the Office of Long-Term Living.

- The Bureau of Coordinated and Integrated Services is responsible for assessing initial readiness and ongoing monitoring of the performance of each CHC-MCO as well as the Independent Enrollment Broker, the independent assessment entity, and the Outreach and Education Entity.
- The Bureau of Quality Assurance and Program Analytics is responsible for monitoring and assessing the performance of the EQRO.

Each Bureau will identify a contract manager to oversee the performance of the contracted entities.

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:

Managed Care Organizations:

Oversight of Pennsylvania's agreements with the managed care organizations will be performed by the Bureau of Coordinated and Integrated Services (BCIS). The agreements with the CHC-MCOs require the CHC-MCO's to submit monthly, quarterly and annual reports to BCIS on internal quality assurance/improvement activities such as consumer and provider surveys, performance measures, complaints and grievances and other issues or concerns that affect network access and service delivery. The Commonwealth monitors program operations and assesses the performance of the plans through these reports.

In addition, in order for the Commonwealth to assess compliance with agreement requirements, an annual agreement compliance monitoring will be conducted. This monitoring will review each agreement requirement through desk reviews and on-site monitoring's as well as face to face visits with selected plan participants to determine satisfaction with program services and plans of care. Deficiencies will be noted, and plans will be required to develop an acceptable Corrective Action Plan within specified time frames. Each plan will be given copies of their respective monitoring reports. Deficiencies involving health and/or safety issues will be expected to be corrected immediately.

The evaluation of the CHC-MCO performance improvement plans (PIPS) will also be evaluated annually by Pennsylvania's External Quality Review Organization (EQRO). The EQRO will assess each plans progress on completing the PIP's and this evaluation will be based on CMS PIP evaluation standards. The evaluation process will assess each plans performance in developing and performing PIPS to improve program outcomes.

Level of Care Determinations/Redeterminations:

OLTL has contracted with an independent Assessment Entity to conduct the Clinical Eligibility Determinations/Redeterminations of participants. A contract manager, located in the Bureau of Coordinated and Integrated Services, will be assigned to this contract and will require quarterly reports on timeliness of the determinations and the agency's adherence to the contract requirements. Monthly and yearly reports on all program requirements will also be required and reviewed for compliance.

The IAE is required to request and complete all assessments electronically via the Pennsylvania Independent Assessment (PIA) system, our individualized assessment system. As assessment results are submitted, the PIA captures all corresponding information and populates various reports that the OLTL can review and monitor during regular intervals (daily, weekly, monthly, quarterly, annually). Reports include the following:

- The number of applicants who have applied for assessments along with result
- Total Requested assessments
- Total Completed assessments
- Total delayed assessments
- Total assessments completed within 10 business days
- Average days to schedule an assessment
- Average days to complete FED on time
- Average days to complete FED minus excuses

Independent Enrollment Broker:

OLTL contracts with a statewide Independent Enrollment Broker (IEB) to facilitate the waiver enrollment process. The IEB is managed in the OLTL Bureau of Coordinated and Integrated Services and assessed with bi-weekly face-to-face or conference call meetings. Performance management as part of the contract includes the following performance measures and data collection:

- Data for all open applications, detailed weekly
- Open applications by time period, weekly summary
- Number of applications at each status in the eligibility process, weekly summary
- All Unduplicated Applications in process during identified time period, detailed monthly
- Timeliness for detailed activities between major milestones, detailed monthly
- Reasons for delayed in-home visit, monthly summary
- Application timeliness, detailed monthly and quarterly
- Problem identification report, as required
- Performance measurement reports measuring timeliness and target criteria contractor must meet or exceed, monthly

In addition, OLTL has included specific Service Level Agreements (SLAs) in the IEB contract which OLTL uses to hold

the vendor accountable to identified levels of performance.

External Quality Review Organization

The EQRO performs its activities under a Department of Human Services statewide contract. Each program office is responsible for monitoring the EQRO's performance for their respective programs. OLTL's Bureau of Quality Assurance and Program Analytics (BQAPA) is responsible for monitoring the EQROs performance for Community HealthChoices. BQAPA will ensure the EQRO follows 42 CFR Part 438, Subpart E, and additional state requirements outlined in the Department's contract with the EQRO. BQAPA will request the Department's contracting officer pursue corrective action plans, ensure tasks are completed in a timely manner or impose monetary penalties for failures of not meeting deliverables.

OLTL continues to operate the OLTL Provider Inquiry Line within the Bureau of Fee for Service Programs to identify and address issues that are not able to be resolved between the CHC-MCO and network providers, such as credentialing delays and claims payment issues. The bureau also operates the OLTL Participant Helpline for participants who are experiencing issues with transition, enrollment, selection of provider, and/or the CHC-MCOs. These hotlines are an early opportunity for DHS to hear about and address issues that might otherwise weaken the program and serve as a vehicle to monitor the program.

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
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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

AA-6: Number and percent of contractual obligations met by the External Quality Review Organization (EQRO). Numerator: Number of contractual obligations met by the EQRO.

Denominator: Total number of contractual obligations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Operations report that measures if EQRO meets work plan due dates

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>

	Continuously and Ongoing	Other Specify: <div>Deliverable based</div>
	Other Specify: <div>Bi-Annually</div>	

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: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

AA-2: Number and percent of functional eligibility determinations (FEDs) completed timely by the Independent Assessment. Numerator: Number of FEDs completed timely. Denominator: Total number of FEDs.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Data system as specified by the State

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:**AA-1: Number and percent of contractual obligations met by the CHC-MCOs Numerator:****Number of contractual obligations met by the CHC-MCOs Denominator: Total number of contractual obligations****Data Source (Select one):****Other**

If 'Other' is selected, specify:

Administrative Data – MCO Operations Reports validated by OLTL

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div>Bi-Annually</div>

Performance Measure:

AA-5: Number and percent of contractual obligations met by the Fiscal Employer Agent (F/EA) and reported to OLTL by the CHC-MCO. Numerator: Number of contractual obligations met by the F/EA. Denominator: Total number of contractual obligations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Administrative Data – CHC-MCO operations Report validated by OLTL.

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 = <div></div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text" value="Bi-Annually"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

AA-4: Number and percent of contractual obligations met by the Independent Enrollment Broker. Numerator: Number of contractual obligations met by the Independent Enrollment Broker. Denominator: Total number of contractual obligations.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Administrative Data – IEB Operations Report validated by OLTL

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

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

AA-7: # and % of complaint reviews, 1st level complaints, 2nd level complaints and 1st level grievances that were resolved within req timeframe N: # of complaint reviews, 1st level complaints, 2nd level complaints and 1st level grievances that were resolved within req timeframe D: Total # of complaint reviews, 1st level complaints, 2nd level complaints and 1st level grievances resolved

Data Source (Select one):

Other

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligations and validated by OLTL

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- 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.

Oversight of the Community HealthChoices Managed Care Organizations (CHC-MCOs) is provided by the Office of Long-Term Living (OLTL) within the Department of Human Services. Each of the CHC-MCOs is monitored under a Core Team, a matrix management model that is a cross-functional group of staff with a variety of skills and experiences. This group works as a team to provide oversight of the CHC-MCOs through both ongoing and quarterly comprehensive monitoring, as well as provide technical assistance to a specific CHC-MCO. The Core Team Manager serves as the primary point of contact for all CHC-MCO-specific issues or concerns and is responsible for utilizing Core Team Members and their analyses to promote performance improvement. Each of the CHC-MCOs is monitored under a Core Team, including a Contract Monitor. The Contract Monitor's primary responsibility is to evaluate the CHC-MCO's performance in designated areas of the contract. Making up the remainder of the team are OLTL staff whose primary responsibility is to evaluate the CHC-MCO's operations and performance requirements. Together, the team manages and monitors a specific plan to make certain contractual, regulatory and programmatic requirements are met and that the members are ensured access to care and quality services. The Core Teams facilitate Quarterly Quality Management meetings with OLTL staff and the CHC-MCOs to discuss CHC-MCO-specific monitoring results.

All CHC-MCOs are expected to adhere to contract requirements, and follow all DHS bulletins, operational memos, and notices that provide guidance and required timeframes for report submissions. All information and reports will be reviewed and analyzed and presented at the monthly Quality Management Meeting. The results of these reports will also serve to develop the agenda for the quarterly Quality Review Meetings with the MCOs. The Core Teams also initiate and follow-up on all Corrective Action Plans (CAPs) that result from monitoring or analysis of reports. For more detailed information regarding OLTL's organizational structure, please refer to Appendix H.

The OLTL Core Teams are the State Medicaid Agency's (OLTL) regional CHC-MCO monitoring agents. The Core Teams are comprised of Registered Nurses, Social Workers and Fiscal Representatives. The teams are dispersed throughout the state of Pennsylvania, and report directly to the Bureau of Coordinated and Integrated Services (BCIS). Using a standard monitoring tool which outlines the CHC-MCO qualifications as listed in the waiver, the Core Teams verify that the CHC-MCO continues to meet each requirement during the review. During the review, a random sample of employee and consumer records is reviewed to ensure compliance with waiver standards. Each CHC-MCO will be reviewed every two years, at minimum. Additionally, the Core Teams will conduct remediation activities as outlined in the waiver application.

The Bureau of Coordinated and Integrated Services (BCIS) also monitors the performance of both the independent assessment entity and the Independent Enrollment Broker. BCIS uses standard monitoring tools which outline the vendor requirements as outlined in the CHC waiver and each respective contract. BCIS verifies that the clinical eligibility and enrollment requirements continue to be met during the reviews.

The Department of Human Services will contract with an External Quality Review Organization (EQRO). The External Quality Review Organization (EQRO) will assist OLTL evaluate the care provided to participants by managed care plans in the areas of quality, access and timeliness. The EQRO will provide reports that will help the Bureau of Quality Assurance and Program Analytics (BQAPA) assess plan results in required quality improvement and performance measurement activities and help both CHC and the plans understand where resources should be focused to further improve the quality of care.

The EQRO will provide services consistent with federal law and policy, including EQR protocols published by CMS. The EQRO will conduct independent series of external quality review activities involving MCOs providing long-term services and supports, physical health services, and behavioral health services, as well as Medicare providers, and assist the state in ensuring coordination of care. The EQRO will also provide an annual report on the analysis and evaluation of aggregated information on quality, timeliness, and access to LTSS, and other services provided by the CHC-MCOs. The EQRO will validate performance measures, performance improvement projects, and conduct desk audits to determine CHC-MCO compliance with federal and state CHC-MCO quality standards. Part of the EQRO's requirements is to conduct on-site audits if desk audits or other activities indicate a need for more information or validation on performance measures. The EQRO will produce an annual technical report to OLTL on mandatory activities. The annual report is designed to comply with federal requirements.

Administration and oversight of these contracts falls within the purview of OLTL and the Department of Human Services.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States 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 performance measures identify Managed Care Organizations (MCOs) that are not meeting their requirements related to review activities as outlined in the contractual agreement, OLTL sends the MCO written notification of outstanding issues with a request for a Corrective Action Plan (CAP). The CAP is due to the OLTL within a mutually agreed time frame appropriate to the issues. OLTL staff reviews and accepts or rejects the CAP. Monitoring by OLTL 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. Beginning July 1, 2022, financial management services became an administrative function of the MCOs. Through a combination of reports utilizing F/EA and administrative data from the MCOs, OLTL determines if the contractual obligations are being met in relation to the Fiscal Employer Agent performance measure. If they are not met, OLTL utilizes the methods described above with the MCOs.

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, the Bureau of Coordinated and Integrated Services (BCIS) notifies the IEB of the specific deficiencies, requests a corrective action plan and follows-up on the plan to ensure compliance. The CAP is due to the Core Teams within 15 working days. BCIS staff reviews and accepts/rejects the CAP within 30 working days. Monitoring by OLTL 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 BCIS.

Through a combination of reports from the independent Assessment Entity and administrative data, the Contract Monitor for the independent Assessment Entity determines if the contractual obligations are being met. If they are not met, BCIS will notify the Assessment Entity of the specific deficiencies, requests a corrective action plan and follows-up on the plan to ensure compliance. The CAP is due to OLTL within 15 working days. BCIS staff reviews and accepts/rejects the CAP within 30 working days. Monitoring by OLTL 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 BCIS.

The External Quality Review Organization (EQRO) will assist OLTL to evaluate the care provided to participants by managed care plans in the areas of quality, access and timeliness. The DHS Contract Monitor for the EQRO determines if the contractual obligations are being met. If they are not met, the Department's Procurement Office will notify the EQRO 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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

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

No**Yes**

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

Appendix B: Participant Access and Eligibility**B-1: Specification of the Waiver Target Group(s)**

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged		65	
		Disabled (Physical)		21	64
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

Waiver services are limited to individuals with physical disabling conditions that are expected to last indefinitely, including individuals with acquired brain injuries and who require a Nursing Facility level of care.

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

Not applicable. There is no maximum age limit

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	107404
Year 2	116996
Year 3	128146
Year 4	140352
Year 5	153698

- 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	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

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).

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 applicants for the CHC HCBS waiver must meet nursing facility level of care requirements as determined by a qualified professional using the Functional Eligibility Determination. After this evaluation, OLTL requires that applicants receive information on all available home and community-based services, including the Living Independence for the Elderly (LIFE) program, as well as institutional services. Applicants then indicate the program of their choice and document the receipt of information regarding their options by electronically completing the OLTL Freedom of Choice form. This form must be signed and dated by the applicant (or his or her legal representative) seeking services and is to be maintained in the applicant's case record.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

§1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

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

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

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

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)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility

group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

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

Specify:

- Individuals Eligible for but not Receiving Cash- 42 CFR § 435.210; 1902(a)(10)(A)(ii)(I); 1905(a); 1902(v)(1)
- Certain Individuals Needing Treatment for Breast or Cervical Cancer- 1902(a)(100(A)(ii)(XVIII); 1902(aa)

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:

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 spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

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

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

OLTL contracted with a non-governmental independent assessment entity to conduct the initial and annual level of care determinations, hereafter referred to as Functional Eligibility Determinations and Redeterminations, respectively. The independent assessment entity performs the initial Functional Eligibility Determinations and annual Redeterminations and ensures the initial Functional Eligibility Determinations are completed 10 days after the participant referral from the Independent Enrollment Broker. The assessment entity is also responsible for validating the results of the annual assessment collected by the CHC-MCOs and officially making the annual Functional Eligibility Redetermination. Lastly, the selected entity is responsible for ensuring that Functional Eligibility Determinations and annual Redeterminations are completed within the required time frames as set forth in policy.

The Independent Assessment Entity sends the completed Functional Eligibility Determination form/tool with supporting documents to the Independent Enrollment Broker who in turn sends the results to the Department of Human Services' County Assistance Office where the final decision on both functional and financial eligibility is made.

Other

Specify:

- 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:

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 local Area Agency on Aging 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 (Medical Doctor) or Chapter 25 (Osteopathic Doctor) of Title 49 PA Code.

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

To be eligible to receive the home and community-based services, an individual must be Nursing Facility Clinically Eligible (NFCE).

An individual is NFCE under Federal and State law and regulations if:

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

The Functional Eligibility Determination tool is used for the evaluation. A physician must certify the level of care need using a physician certification form, which indicates the physician's diagnosis and clinical eligibility recommendation.

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

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

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

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

Initial Level of Care Evaluation – OLTL uses the following process to determine an individual's initial level of care:

- The applicant first applies for CHC Waiver services through the statewide Independent Enrollment Broker (IEB).
- The IEB makes a referral to the assessment entity for a functional eligibility determination and assists the applicant with obtaining a completed physician certification form from the applicant's physician (M.D. or D.O.).
- The assessment entity assessor visits the applicant within 10 days of receiving the referral from the IEB and uses the standardized Functional Eligibility Determination tool to identify information regarding the applicant's medical status, recent hospitalizations, and functional ability (ADLs and IADLs). The Functional Eligibility Determination tool is used in all 67 counties for all individuals entering a home and community-based waiver, LIFE and to determine institutional level of care.
- The applicant's physician completes the physician certification form and returns the form to the IEB. The physician certification form captures the following information:
 - o Physician's recommendation of level of care
 - o Diagnosis
 - o ICD-10 code
 - o Length of care required – short-term (180 days or less) or long-term (more than 180 days)
 - o Physician's signature, license number and contact information
- The IEB follows the status of the initial functional eligibility determination process and assists with any required communication between the applicant, the applicant's physician, and the assessment entity.
- The independent assessment entity will make a recommendation relating to functional eligibility for final approval by OLTL. In instances where the certification of the applicant's physician and the recommendation of the assessor differ on clinical eligibility determination, OLTL's Medical Director will review the collected documentation and make the final determination. The OLTL Medical Director and a clinical team comprised of registered nurses (RN) will complete a clinical review of a sample of applicants that are determined Nursing Facility Ineligible (NFI). The review is to ensure oversight of the functional assessment determination process.

Annual Redetermination – OLTL uses the following process for the annual redetermination of waiver participants:

- The participant's CHC-MCO will be responsible for collecting the necessary information and documentation to complete the functional eligibility determination using the standardized needs assessment tool. This information is then forwarded to the assessment entity for the annual redetermination of functional eligibility.
- The assessment entity is responsible for validating the results of the documentation collected by the CHC-MCOs making the final functional eligibility determinations, subject to OLTL oversight.

As stated above, in instances where the applicant's physician and the assessor differ on the final functional eligibility determination, OLTL's Medical Director will review the collected documentation and make the final determination. The OLTL Medical Director and a clinical team comprised of RNs will complete a clinical review of a sample of applicants that are determined Nursing Facility Ineligible (NFI). The review is to ensure oversight of the functional assessment determination process.

A contract manager, who is an employee of the Office of Long-Term Living, will be assigned to oversee the independent assessment entity contract and will require monthly reports on timeliness of the determinations and the agency's adherence to the contract requirements. A yearly report on all program requirements will also be required and reviewed for compliance.

OLTL maintains Administrative Authority over the initial evaluation and annual reevaluation processes by monitoring the timeliness and appropriateness of level of care evaluations and reevaluations referenced in the Quality Improvement section below.

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

A redetermination is required every 365 days or sooner if there is a significant change in condition.

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform

reevaluations (*select one*):

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

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

The CHC-MCO will ensure that a meeting with the participant in the participant's home takes place to collect the information/documentation required to reassess the participant's need for waiver services. Each CHC-MCO will be required to maintain its own tickler system to complete timely reevaluations and maintain consistency in service. CHC-MCO's are required to collect the information necessary for redeterminations every 365 days or more frequently as needed.

The information/documentation gathered will then be forwarded to the assessment entity before 365 days of the prior evaluation/reevaluation for determination of on-going eligibility of the participant.

Additionally, OLTL will receive regular reports from both the CHC-MCO and the assessment entity detailing the timeliness and accuracy of the reevaluations. This information will be reviewed by the Bureau of Quality Assurance and Program Analytics and the Bureau of Fee for Service Programs within OLTL and corrective action will be taken if either party fails to meet identified standards.

- 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:

Data will be stored in the Commonwealth's Enterprise Data Warehouse where all participant information is stored and maintained. This includes enrollment data, eligibility information, incident management, and billing and claims management.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

LOC-1: Number and percent of new enrollees who have an initial Functional Eligibility Determination (FED) completed prior to receipt of waiver services

Numerator: Total number of new enrollees who have a valid FED prior to the receipt of waiver services Denominator: Total number of new enrollees

Data Source (Select one):

Other

If 'Other' is selected, specify:

PA Individualized Assessment (PIA)

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

LOC-2: Number and percent of FEDs that were completed in accordance with policies and procedures
Numerator: Number of FEDs that were done correctly
Denominator: Total number of FEDs reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Administrative Data – FED Entity Operations Report validated by OLTL

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 = <div>95% +/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div>Bi-Annually</div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- 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.

OLTL has entered into a sole-source contract with a non-governmental, non-state, conflict-free and independent assessment entity to conduct the initial and annual level of care determinations, hereafter referred to as Functional Eligibility Determinations and Re-determinations, respectively. The selected Independent Assessment Entity has subcontracts with local organizations to perform the initial Functional Eligibility Determinations and annual Redeterminations and is responsible for monitoring these local organizations to ensure the initial Functional Eligibility Determinations are completed 10 days after the participant referral from the Independent Enrollment Broker. The selected entity is also responsible for validating the results of the annual assessment collected by the CHC-MCO and officially making the annual Functional Eligibility Redetermination. Lastly, the selected entity is responsible for ensuring that Functional Eligibility Determinations and annual Redeterminations are completed within the required timeframes as set forth in policy.

The Bureau of Coordinated and Integrated Services will conduct quality management and improvement monitoring of the independent Assessment Entity. This includes ensuring that the Assessment Entity complies with federal and state regulations, and the delivery of services as outlined in their Statement of Work. BCIS will also monitor to ensure program and service delivery systems achieve desired outcomes.

The following reports will be utilized to determine that Functional Eligibility Determinations are being conducted and applied accurately.

Initial FED Completion Report – A report of the number of LTSS applicants who have been referred for a FED, and number of completed FEDs minus excuses.

Length of Time (Days) for Initial FED Completed for Applicant– A report of the number of days from the date FED was requested, the date due and the total number of days to complete the FED minus excuses.

Length of Time (Days) for “in person” Annual Redeterminations for Participants Completed for Applicant by County and Subcontractor – A report of the number of days from the date an annual redetermination was requested by a SCE to the date the annual redetermination was completed minus excuses.

Length of Time (Days) for Annual Redetermination completed for CHC Participants – A report of the number of days from the date annual redetermination data from FED form is supplied by CHC MCO to the date desk review was completed.

FED Comparison Results Report – The independent assessment entity will provide a FED Comparison Results report that includes data from FEDs completed each quarter to determine whether the percentages of those found eligible or ineligible have deviated either way in a significant manner. The Entity will also provide a final year-end month to month comparison on the quarterly findings.

The CHC-MCO must conduct a comprehensive needs reassessment no more than 12 months following the most recent prior comprehensive needs assessment or comprehensive needs reassessment unless a trigger event occurs. The CHC-MCO must complete reassessments as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant’s health status and needs, but in no case more than 14 days after the occurrence of the following trigger events:

- A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings, or a hospital discharge.
- A change in functional status.
- A change in caregiver or informal support status if the change impacts one or more areas of health or functional status.
- A change in the home setting or environment if the change impacts one or more areas of health or functional status.
- A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning.
- As requested by the Participant or designee, caregiver, Provider, or the PCPT or PCPT Participant, or the Department.

In addition to the trigger events listed above, if the CHC-MCO identifies that a participant has not been receiving

services for (5) or more consecutive service days to assist with activities of daily living as indicated on the service plan, and if the suspension of services was not pre-planned, then the CHC-MCO must communicate with the participant to determine the reason for the service suspension within 24 hours of identifying the issue. If the participant's health status or needs have changed, then the CHC-MCO must conduct a comprehensive needs reassessment of the participant's needs within fourteen (14) days of identifying the issue.

Through the comprehensive needs assessment and reassessment, the CHC-MCO must assess a Participant's physical health, behavioral health, social, psychosocial, environmental, caregiver, LTSS, and other needs as well as preferences, goals, housing, and informal supports.

MCOs are required to enter the assessment information into the commonwealth approved tool and the independent assessment entity reviews for accuracy. Discrepancies will be sent to commonwealth staff for adjudication.

As previously stated, the Medical Director for OLTL will be highly involved in the FED process. In instances where the applicant's physician and the assessor differ on the final functional eligibility determination, OLTL's Medical Director will review the collected documentation and make the final determination. The OLTL Medical Director and a clinical team comprised of RNs will complete a clinical review of a sample of applicants that are determined Nursing Facility Ineligible (NFI). The review is to ensure oversight of the functional assessment determination process.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States 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 Bureau of Coordinated and Integrated Services reviews FED data in the commonwealth approved data system and identifies non-compliance regarding the timeliness or specifications of initial FED or annual Redetermination, the independent Assessment Entity will be notified immediately, and the non-compliance issue will be discussed along with an immediate remediation plan. Should non-compliance issues continue, a Corrective Action Plan (CAP) is requested from the independent Assessment Entity as referenced above in (b)(i).

ii. Remediation Data Aggregation

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

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

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

The Commonwealth of Pennsylvania assures CMS that when a Nursing Facility (NF) or community resident applies for CHC 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 services, 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 of their right to choose between receiving community services in the waiver, LIFE, NF services, or choose not to receive services. All eligible participants will execute his/her choice during the initial enrollment process and annually during the development of the person-centered service plan. 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 choice of CHC-MCOs, and electronically documenting the participant's choice of CHC-MCO. After the participant selects a CHC-MCO, the IEB will process the enrollment and refer the participant to the selected managed care plan for services.

The CHC-MCO must offer the Participant the choice of at least two Service Coordinators. If a Participant does not select a Service Coordinator within seven (7) business days of Enrollment for a comprehensive needs assessment, the CHC-MCO must make an automatic assignment of Service Coordinator. The CHC-MCO must consider such factors (to the extent they are known), as current Provider relationships, the person assigned to the Participant for care management in the CHC-MCO's aligned D-SNP, specific medical needs, physical disabilities of the Participant, language needs, area of residence and access to transportation. The CHC-MCO must then notify the Participant by telephone or in writing of his/her Service Coordinator's name, location and office telephone number. The CHC-MCO must make every effort to determine Service Coordination choice and confirm this with the Participant prior to the commencement of the CHC-MCO coverage in accordance with Participant Enrollment and Disenrollment, so that new Participants do not go without a Service Coordinator for a period of time after Enrollment begins or after assessment of needs for LTSS.

The participant also has the freedom to choose any qualified provider in the CHC-MCO's network to receive waiver services. The Service Coordinator is responsible for ensuring participants are fully informed of their right to choose willing and qualified service providers within the network at the time of development of the initial Person-Centered Service Plan, at each reevaluation, and at any time during the year when a participant requests a change of providers. The Service Coordinator is responsible for documenting the participant's choice of provider electronically as part of the participant's Person-Centered Service Plan.

- 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.

The Independent Enrollment Broker (IEB) will collect for each waiver applicant their Freedom of Choice regarding where they receive services and Service Provider Choice of MCO, via an electronic record as part of the enrollment process. The IEB will submit this information to the chosen MCO upon each individual's enrollment in the CHC-MCO. The CHC-MCO will maintain these records in participant files.

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):

During the Enrollment Process, the Independent Enrollment Broker must identify CHC applicants who speak or read a language other than English as their first language and must communicate using the spoken and written language preferences identified by those applicants. The IEB must provide, at no cost to the applicants, oral interpretation services in their requested language or sign language interpreter services to meet the needs of CHC applicants. The IEB must provide oral interpretation services in all languages requested by CHC applicants. The IEB must also have a sufficient number of staff who are bilingual in English and Spanish to interact with CHC applicants.

In addition, the IEB must translate Vital Documents into Spanish or one of the other five (5) most prevalent languages in Pennsylvania, as designated by DHS if a translated document is requested by a CHC applicant with LEP. The IEB must include a notice of nondiscrimination and taglines in all large significant publications and large significant communications targeted to IEB Consumers, and members of the public. Large significant publication/communication taglines must be printed in a conspicuously-visible font size (font size no smaller than 12 point) in the fifteen (15) prevalent languages in Pennsylvania.

The CHC-MCO must communicate with the individual using spoken and written language preferences identified by the IEB in all contact(s) with the Participant.

The CHC-MCO must provide, at no cost to Participants, oral interpretation services in the requested language to meet the needs of Participants. The CHC-MCO must also provide specialized interpretive services to ensure access to services for Participants who are deaf and blind. Oral interpretation requirements apply to all non-English languages, not just those that are identified as prevalent. The CHC-MCO must notify Participants that oral interpretation for any language, and written translation in prevalent languages, and auxiliary aids and services are available upon request at no cost to the Participant. The CHC-MCO must require Network Providers to offer interpretation services and prohibit Network Providers from requiring a Participant's family member be used for interpretation. These services must also include all services dictated by federal requirements. If a Network Provider is unable or unwilling to provide these services, the CHC-MCO must provide interpretation services.

The CHC-MCO must make all vital documents disseminated to English speaking Participants available in the prevalent languages designated by the Department. Documents may be deemed vital if related to the access to programs and services and include informational material. Vital documents include Provider Directories, Participant handbooks, appeal and grievance notices, and other notices that are critical to obtaining services. The CHC-MCO must include appropriate instructions in all materials about how to access or receive assistance to access materials in an alternate language.

Vital documents must be posted on the CHC-MCOs website.

The CHC-MCO must also provide alternative methods of communication for Participants who are visually or hearing impaired or both, including Braille, audio tapes, large print, compact disc, DVD, computer diskette, special support services, and/or electronic communication. The CHC-MCO must, upon request from the Participant, make all written materials disseminated to Participants accessible to visually impaired Participants. The CHC-MCO must provide TTY and/or Pennsylvania Telecommunication Relay Service for communicating with Participants who are deaf or hearing impaired, upon request.

The CHC-MCO must include in all written materials must include taglines in the prevalent languages identified by the Department, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the CHC-MCO's call center. Large print means printed in a font size no smaller than 18 points.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Daily Living		
Statutory Service	Employment Skills Development		
Statutory Service	Job Coaching		
Statutory Service	Personal Assistance Services		

Service Type	Service		
Statutory Service	Residential Habilitation		
Statutory Service	Respite		
Statutory Service	Structured Day Habilitation Services		
Extended State Plan Service	Counseling Services		
Extended State Plan Service	Home Health Aide Services		
Extended State Plan Service	Nursing Services		
Extended State Plan Service	Occupational Therapy Services		
Extended State Plan Service	Physical Therapy Services		
Extended State Plan Service	Specialized Medical Equipment and Supplies		
Extended State Plan Service	Speech and Language Therapy Services		
Other Service	Assistive Technology		
Other Service	Behavior Therapy		
Other Service	Benefits Counseling		
Other Service	Career Assessment		
Other Service	Cognitive Rehabilitation Therapy Services		
Other Service	Community Integration		
Other Service	Community Transition Services		
Other Service	Home Adaptations		
Other Service	Home Delivered Meals		
Other Service	Job Finding		
Other Service	Non-Medical Transportation		
Other Service	Nutritional Consultation		
Other Service	Participant-Directed Community Supports		
Other Service	Participant-Directed Goods and Services		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Pest Eradication		
Other Service	TeleCare		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Daily Living

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Adult Daily Living services are designed to assist participants in meeting, at a minimum, personal care, social, nutritional and therapeutic needs. Adult Daily Living services are necessary, as specified by the service plan, to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

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

Adult Daily Living services are generally furnished for four (4) or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a non-institutional, community-based center encompassing both health and social services needed to ensure the optimal functioning of the participant.

Adult Daily Living includes two components:

- Basic Adult Daily Living services
- Enhanced Adult Daily Living services.

Basic Adult Daily Living services are comprehensive services provided to meet the needs noted above in a licensed center. Per Subchapter A, and 11.123 Core Services, the required core services for these settings include personal assistance, nursing in accordance with regulation, social and therapeutic services, nutrition and therapeutic diets and emergency care for participants. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Basic Adult Daily Living services can be provided as either a full day or a half day. The individual's service plan initiates and directs the services they receive while at the center.

In addition to providing Basic Adult Daily Living services, Enhanced Adult Daily Living services must include the following additional service elements:

- **Nursing Requirement:** The Enhanced Adult Daily Living provider shall directly provide, contract for, or otherwise arrange for nursing services. In addition to the requirements found in the Older Adult Daily Living Center (OADLC) Regulations § 11.123 (2), a Registered Nurse (RN) must be available on-site one (1) hour weekly for each enrolled waiver participant. At a minimum, each waiver participant must be observed every other week by the RN with the appropriate notations recorded in the participant's service plan, with the corresponding follow-ups being made with the participant, family, or physician.
- **Staff to Participant Ratio:** Staffing of OADLC providing Enhanced services will be at a staff to participant ratio of 1:5.
- **Operating Hours:** To be eligible for the minimum rate associated with Enhanced Services, the OADLC must be open a minimum of eleven (11) hours daily during the normal work week. A normal work week is defined as Monday through Friday. (If open on a Saturday or Sunday the eleven-hour requirement is not in effect for the weekend days of operation.)
- The guidelines for the required specialized services for the OADLC provider to include physical therapy, occupational therapy, speech therapy, and medical services can be found in Subchapter B, § 11.402.
- Enhanced Adult Daily Living services can be provided as either a full day or a half day.
- For Adult Daily Living providers that are certified as Enhanced, all participants attending that center are considered to be receiving Enhanced services.

As necessary, Adult Daily Living may include assistance in completing activities of daily living and instrumental activities of daily living. This service also includes assistance with medication administration and the performance of health-related tasks to the extent State law permits.

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

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

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

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

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

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

Participant-directed as specified in Appendix E

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	Adult Day Center
Agency	Older Adult Daily Living Center

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Daily Living

Provider Category:

Agency

Provider Type:

Adult Day Center

Provider Qualifications

License (*specify*):

Meet licensing regulations under Title 55 PA Code, Chapter 2380, Subchapter A

Certificate (*specify*):

N/A

Other Standard (specify):

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Adult Daily Living

Provider Category:

Agency

Provider Type:

Older Adult Daily Living Center

Provider Qualifications**License (specify):**

Meet licensing regulations under Title 6 PA Code, Chapter 11, Subchapter A

Certificate (specify):

N/A

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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:

Prevocational Services

Alternate Service Title (if any):

Employment Skills Development

HCBS Taxonomy:**Category 1:**

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:

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Sub-Category 2:

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Category 3:

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Sub-Category 3:

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Service Definition (Scope):**Category 4:**

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Sub-Category 4:

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Employment Skills Development services provide learning and work experiences, including volunteer work, where the participant can develop strengths and skills that contribute to employability in paid employment in integrated community settings. Services are aimed at furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage. Employment Skills Development services are necessary, as specified in the service plan, to support the participant to live and work successfully in home and community-based settings, enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

Employment Skills Development services are designed to:

- Be individually tailored to directly address the participant's employment goals as identified in the needs assessment and included in the service plan. If the participant has received a Career Assessment that has determined that the participant is in need of acquiring particular skills in order to enhance their employability, those identified skills development areas must be addressed within the participant's service plan and by the Employment Skills Development service.
- Enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's career goals, interests, strengths, priorities, abilities and capabilities, while following applicable federal and State wage guidelines.
- Support acquisition of skills needed to obtain competitive, integrated employment in the community.
- Develop and teach general, translatable skills including, but not limited to, the ability to communicate effectively with supervisors, coworkers and customers; generally accepted community workplace conduct and dress; basic workplace requirements, like adherence to time and attendance expectations; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety; and training to enable the effective use of transportation resources.
- Provide and support the acquisition of skills necessary to enable the participant to obtain competitive, integrated work where the compensation for the participant is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by participants without disabilities, which is considered to be the optimal outcome of Employment Skills Development services.

Support may be provided to participants for unpaid volunteer placement and training experiences, which may be provided in community-based settings. Volunteering is not an alternative to paid employment, but rather must be an avenue for building skills and connections that are expected to lead to competitive integrated employment. Volunteer placements used for the purpose of Employment Skills Development must be time limited, and it must be documented in the service plan how the volunteer placement is expected to achieve the goal of competitive integrated employment. Skills development as a part of placement and training may occur as a one to one training experience or in a group setting in accordance with Department requirements.

Employment Skills Development includes transportation as an integral component of the service, for example, transportation to a volunteer or training activity.

Employment Skills Development includes Personal Assistance, but may not comprise the entirety of the service.

Employment Skills Development may be provided in facilities licensed under PA Code 2390 but only after the participant has been referred to OVR and the following is documented: the participant was either determined ineligible by OVR or their OVR case is closed and the provision of Employment Skills Development services has already been attempted in a competitive integrated employment setting or an unlicensed community-based setting outside the participant's home.

Participants receiving Employment Skills Development services must have measurable employment-related goals in their service plan.

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.

If the participant receives Behavior Therapy services, this service includes implementation of the behavior support plan and, if necessary, the crisis support plan. The service includes collecting and recording the data necessary to support the review of the service plan, the behavior support plan and the crisis support plan, as appropriate.

Employment Skills Development services are delivered up to a 1:3 staff to client ratio when the service is delivered in the community, and up to a 1:15 staff to client ratio when delivered in a facility-based environment in accordance with 55 PA Code Chapter 2390.

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

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

Employment Skills Development services may not be rendered under the waiver to a participant under a program funded by the Rehabilitation Act of 1973 as amended or any other small business development resource available to the participant. This means that Employment Skills Development may only be provided when documentation has been obtained that one of the following has occurred:

1. OVR has closed a case for the participant or has stopped providing services to the participant;
2. The participant was determined ineligible for OVR services; or
3. It has been determined that OVR services are not available. If OVR has not made an eligibility determination within 120 days of the referral being sent, then OVR services are considered to not be available to the participant.

In the event that OVR closes the order of selection, the following process will be followed until the closure is lifted:

1. A participant who has been referred to OVR but does not have an approved Individualized Plan for Employment (IPE) may receive Employment Skills Development.
2. A participant who has not been referred to OVR may receive Employment Skills Development without a referral to OVR.

Documentation in accordance with Department requirements must be maintained in the file by the Service Coordinator and updated with each reauthorization to satisfy the State assurance that the service is not otherwise available to the participant under other federal programs.

Total combined hours for Employment Skills Development, and Job Coaching services are limited to 50 hours in a calendar week.

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.

Handicapped employment, as defined in Title 55, Chapter 2390, may not be funded through the waiver. Waiver funding is not available for the provision of Employment Skills Development (e.g., sheltered work performed in a facility) where participants are supervised in producing goods or performing services under contract to third parties.

Employment Skills Development services are limited to 36 continuous months, at which time the participant should be able to pursue Job Finding, Job Coaching or another service setting where they may utilize skills they have gained. Exceptions to this limit may be considered based upon a needs assessment or Career Assessment and prior authorization by the Department.

Employment Skills Development services are not a pre-requisite for Job Finding or Job Coaching.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Employment Skills Development Provider
Agency	Vocational Facilities

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Employment Skills Development****Provider Category:**

Agency

Provider Type:

Employment Skills Development Provider

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used as a component of the Employment Skills Development service

One of the following within 18 months of employment:

1. Holds a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE)
2. Has been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
 - Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
 - Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
 - Have Commercial General Liability insurance
 - Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age
 - Have a minimum of 1 year of experience living or working with an individual with a disability or individuals with support needs commensurate with participants served in the waiver or related educational experience
 - Comply with all Department standards including regulations, policies and procedures related to provider qualifications
 - Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
 - Individuals without certification must be supervised by an individual holding the above certification until certification is achieved. Certification must be achieved within 18 months of employment.
 - 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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: Employment Skills Development

Provider Category:

Agency

Provider Type:

Vocational Facilities

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certificate of Compliance per 55 PA Code Chapter 2390

Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used as a component of the Employment Skills Development service

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
 - Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
 - Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
 - Have Commercial General Liability insurance
 - Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age
 - Have a minimum of 1 year of experience living or working with an individual with a disability or individuals with support needs commensurate with participants served in the waiver or related educational experience
 - Comply with all Department standards including regulations, policies and procedures related to provider qualifications
 - Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
 - Have a 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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:

Supported Employment

Alternate Service Title (if any):

Job Coaching

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Job Coaching services are individualized services providing supports to participants who need ongoing support to learn a new job and maintain a job that meets the definition of competitive integrated employment. Competitive integrated employment is full or part-time work at minimum wage or higher, with wages and benefits similar to those without disabilities performing the same work, and fully integrated with co-workers without disabilities. Job Coaching can also be used to support participants who are self-employed. Job Coaching services are necessary, as specified in the service plan, to support the participant to live and work successfully in home and community-based settings, enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

Competitive integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age.

Job Coaching provides two components in accordance with an assessment: Intensive Job Coaching and Extended Follow-along.

Intensive Job Coaching

Intensive Job Coaching is an essential component of Job Coaching services and may include:

- On the-job training and skills development;
- Assisting the participant with development of natural supports in the workplace; and,
- Coordinating with employers or employees, coworkers and customers, as necessary.

Intensive Job Coaching includes assisting the participant in meeting employment expectations, performing business functions, addressing issues as they arise, and also includes travel training and diversity training to the specific business where the participant is employed. Intensive Job Coaching provides support to assist participants in stabilizing in an integrated situation (including self-employment) and may include meeting with employers on behalf of the participant when the participant is not present to assist in maintaining job placement. Participants receiving Intensive Job Coaching require on-the-job support for more than 20% of their work week at the outset of the service, phasing down to 20% per week during the Intensive Job Coaching period (at which time, Extended Follow-along will be provided if ongoing support is needed). Job Coaching supports within this range will be determined based on the participant's needs.

Intensive Job Coaching for the same employment site and/or position may only be authorized for up to 6 months and may be reauthorized for additional 6 month periods, upon review with the service planning team. Intensive Job Coaching may only be reauthorized twice, for a total of 18 consecutive months of Intensive Job Coaching support for the same employment site and/or position. Any exceptions require prior approval from the Department or its designee. Intensive Job Coaching is recommended for new employment placements or may be reauthorized for the same location after a period of Extended Follow-along, due to change in circumstances (new work responsibilities, personal life changes, etc.).

Extended Follow Along

Extended Follow-along is ongoing support available for an indefinite period as needed by the participant to maintain their paid employment position once they have been stabilized in their position (receiving less than 20% onsite support for at least four weeks). Extended Follow-along support may include reminders of effective workplace practices and reinforcement of skills gained during the period of Intensive Job Coaching. Once transitioned to Extended Follow-along, providers are required to make at least 2 visits per month, up to a maximum of 240 hours per service plan year. This allows an average of 20 hours per month to manage difficulties which may occur in the workplace and the limit may be used for the participant over an annual basis, as needed. If circumstances require more than that amount per service plan year, the service must be billed as Intensive Job Coaching.

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.

Job Coaching does not include the provision of Personal Assistance Services.

If the participant receives Behavior Therapy services, this service includes implementation of the behavior support plan and, if necessary, the crisis support plan. The service includes collecting and recording the data necessary to support the review of the service plan, the behavior support plan and the crisis support plan, as appropriate.

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

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

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

Job Coaching services may not be rendered under the waiver to a participant under a program funded by the Rehabilitation Act of 1973 as amended or any other small business development resource available to the participant. This means that Job Coaching may only be provided when documentation has been obtained that one of the following has occurred:

1. OVR has closed a case for the participant or has stopped providing services to the participant;
2. The participant was determined ineligible for OVR services; or
3. It has been determined that OVR services are not available. If OVR has not made an eligibility determination within 120 days of the referral being sent, then OVR services are considered to not be available to the participant.

In the event that OVR closes the order of selection, the following process will be followed until the closure is lifted:

1. A participant who has been referred to OVR but does not have an approved Individualized Plan for Employment (IPE) may receive Job Coaching.
2. A participant who has not been referred to OVR may receive Job Coaching without a referral to OVR.

Documentation in accordance with Department requirements must be maintained in the file by the Service Coordinator and updated with each reauthorization to satisfy the State assurance that the service is not otherwise available to the participant under other federal programs.

Total combined hours for Employment Skills Development, or Job Coaching services are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must obtain prior approval.

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.

Federal Financial Participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in Job Coaching services
- Payments that are passed through to users of Job Coaching services

Job Coaching does not include facility-based or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.

Job Coaching does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Job Coaching Agency
Individual	Job Coaching Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Job Coaching

Provider Category:

Agency

Provider Type:

Job Coaching Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used as a component of the Job Coaching service

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
 - Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
 - Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
 - Have Commercial General Liability insurance
 - Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age,
 - Have a High School Diploma or GED and 2 years related experience, or
 - Have a bachelor's degree, and
 - Have a minimum of 1 year of experience living or working with an individual with a disability or support needs commensurate with the participants served in the waiver or related educational experience, or
 - Meet the qualifications for a Vocational Rehabilitation Counselor, as defined by the PA Department of Labor and Industry, Office of Vocational Rehabilitation.
 - Comply with all Department standards including regulations, policies and procedures related to provider qualifications
 - Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
 - Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
- Individuals working directly with the participant to provide job coaching services shall hold one of the following within 18 months of employment:
- Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE)
 - Been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.
 - Individuals who meet the qualifications for a Vocational Rehabilitation Counselor are exempt from this provision.
 - Individuals without certification must be supervised by an individual holding the above certification until certification is achieved. Certification must be achieved within 18 months of employment.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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: Job Coaching

Provider Category:

Individual

Provider Type:

Job Coaching Provider

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used as a component of the Job Coaching service.
See "Other Standard"

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
- Have Commercial General Liability insurance
- Be at least 18 years of age
- Have a minimum of 1 year of experience living or working with an individual with a disability or support needs commensurate with the participants served in the waiver or related educational experience, and
- Have a High School Diploma or GED and 2 years related experience, or
- Bachelor's degree; or
- Meet the qualifications for a Vocational Rehabilitation Counselor, as defined by the PA Department of Labor and Industry, Office of Vocational Rehabilitation; and
- One of the following within 18 months of employment:
- Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE)
- Been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.
- Individuals who meet the qualifications for Vocational Rehabilitation Counselors are exempt from certification provision.
- Individuals without certification must be supervised by an individual holding the above certification until certification is achieved. Certification must be achieved within 18 months of employment; and
- 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

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Assistance Services

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Personal Assistance Services (PAS) primarily provide hands-on assistance, including cueing and supervision as described below, to participants that are necessary, as specified in the service plan, to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

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

PAS is 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 PAS provides intermittent or ongoing awake, overnight assistance to a participant in their home for up to eight hours. This assistance may include the following types of activities as examples but it is not an exhaustive list: physical assistance or supervision with toileting, transferring, turning/repositioning, assisting/monitoring intake of liquids, mobility issues that may result in fall risks, and verbal prompt/reminders to take medication. The participant's PCSP must document an assessed need for PAS and any activity beyond what can be provided through the Personal Emergency Response System (PERS) or TeleCare Services. Overnight PAS requires awake staff.

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

- Accompanying the participant into the community for purposes related to PAS, 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, and to enable the participant to work and to otherwise engage in activities in the community.
- Homemaker tasks that are incidental to the delivery of PAS 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.

The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021 in accordance with the Good Faith Exemption granted by the Centers for Medicare & Medicaid Services and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

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

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

PAS workers may accompany participants into the community when the need is documented in the participant's PCSP. Costs incurred by the PAS workers while accompanying the participant into the community, such as admission fees, are not reimbursable under the waiver as PAS.

In addition, PAS workers may provide transportation to participants as long as the transportation is associated with the provision of PAS, necessary for the participant to work or engage in the community and documented in the participant's PCSP.

PAS cannot be used to solely transport a participant as this would be considered Non-Medical Transportation services which are available in the waiver. In order to bill for PAS, the participant must have a need for PAS while in community locations for which transportation is necessary and is documented in the participant's PCSP. PAS workers may provide and bill for Non-Medical Transportation services, however it may not be billed simultaneously with PAS. The PAS worker providing the non-medical transportation services must meet the state's provider qualifications for transportation services and be enrolled in Medical Assistance as a transportation provider or enrolled with the applicable CHC-MCO's non-medical transportation broker.

PAS services are provided only for the participant and not for other household members, and only when neither the participant nor anyone else in the household, relative or informal caregiver is available, willing, and able to perform such activities for the participant and where no other community/volunteer agency or third-party payer is capable or responsible for their provision.

PAS workers who live in the same residence as the participant cannot be compensated for carrying out household chores such as shopping, laundry and cleaning unless the activity is being completed solely to benefit the participant.

PAS cannot be provided simultaneously with Home Health Aide, Residential Habilitation, Respite or Participant-Directed Community Supports. An individual cannot provide both PAS and Non-Medical Transportation simultaneously.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Individual	Personal Assistance Worker

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Assistance Services**Provider Category:**

Agency

Provider Type:

Home Care Agency

Provider Qualifications**License** (*specify*):

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

Certificate (*specify*):

N/A

Other Standard (*specify*):

Agency:

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

Individuals working for agencies must meet the following standards: Be 18 years of age or older;

- Possess basic math, reading, and writing skills; Complete training or demonstrate competency by passing a competency test as outlined in Section 611.55 under Title 28, Part IV Subpart H of the Health Care Facilities Act;
- Have the required skills to perform services as specified in the participant's service plan;
- Complete any necessary pre/in-service training related to the participant's service plan;
- Agree to carry-out outcomes included in the participant's service plan;
- Possess a valid Social Security number;
- Must pass criminal records check as required in 55PA Code Chapter 52 Section 52.19;
- Have a child abuse clearance as required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation, or 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:

Personal Assistance Worker

Provider Qualifications**License** (*specify*):

N/A

Certificate (*specify*):

N/A

Other Standard (*specify*):

Personal Assistance workers must:

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Be 18 years of age or older;
- Possess basic math, reading, and writing skills;
- Possess a valid Social Security number;
- Submit to a criminal records check;
- Have a child abuse clearance as required in Appendix C-2-b;
- Have the required skills to perform PAS 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:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:**Service:****Alternate Service Title (if any):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Residential Habilitation Services are delivered in provider owned, rented/leased or operated settings. They can be provided in Licensed and unlicensed settings.

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

Residential Habilitation services are provided for up to 24 hours a day. This service is authorized as a day unit. A day is defined as a period of a minimum of 8 hours of service rendered by a residential habilitation provider within a 24-hour period beginning at 12:00 am and ending at 11:59 pm. Residential Habilitation services are designed to assist an individual in acquiring the basic skills necessary to maximize their independence in activities of daily living and to fully participate in community life. Residential Habilitation services are individually tailored to meet the needs of the individual as outlined in the person-centered service plan.

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

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

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

Residential Enhanced Staffing may be provided at the following levels:

- Level 1: staff-to-individual ratio of 1:1.
- Level 2: staff-to-individual ratio of 2:1 or greater.

Licensed settings serving individuals enrolled in the CHC Waiver may not exceed a licensed capacity of more than 8 unrelated individuals. Both licensed and unlicensed settings must be community-based as well as maintain a home-like environment. A home-like environment provides full access to typical facilities found in a home such as a kitchen and dining area, provides for privacy, allows visitors at times convenient to the individual, and offers easy access to resources and activities in the community. Residences are expected to be located in residential neighborhoods in the community. Participants have access to community activities, employment, schools or day programs. Each facility shall assure to each participant the right to live as normally as possible while receiving care and treatment. Home and Community character will be monitored by the CHC-MCOs through ongoing monitoring. Additionally, Service Coordinators will monitor the community character of the residence during regularly scheduled contact with residents. Results of this monitoring will be reported to OLTL. Service Coordinators assist participants in transitioning to homes of their own.

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

Payment is not made for room and board.

Residential Habilitation services do not include the provision of a structured day habilitation, adult daily living, job coaching, employment skills development, and therapies provided on a one to one basis.

Community Integration, Home Health Care Aide services, Non-Medical Transportation, Personal Assistance Services, TeleCare, Vehicle Modifications, Home Adaptations, Home Delivered Meals, Participant-Directed Community Supports, Participant-Directed Goods and Services, and Respite cannot be provided at the same time as Residential Habilitation.

Long-term or Continuous Nursing cannot be on the same service plan as Residential Habilitation. The CHC-MCO may consider an exception to the limitation on long-term or continuous nursing and Residential Habilitation Services with documentation from the Service Coordinator that supports the participant's need to receive both services.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Unlicensed Residential Habilitation Provider

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

CARF Community Housing accreditation or CARF Brain Injury Residential Rehabilitation Program (Adult) accreditation

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver Provider Agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
- Comply with 42 CFR §441.301(c)(4) and (5) specific to allowable settings for home and community-based waiver services;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a waiver service location in Pennsylvania;
- Have Commercial General Liability Insurance
- Have Professional Liability Errors and Omissions Insurance
- Have Workers Compensation Insurance in accordance with State statute and in accordance with Department policies;
- Ensure that employees have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs.

Individuals employed to provide Residential Habilitation services must:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Licensed Residential Habilitation Provider

Provider Qualifications

License (*specify*):

Licensed by the PA Department of Public Welfare, per 55 PA Code 2600, Personal Care Homes or 55 PA Code 2800, Assisted Living Residence

Certificate (*specify*):

CARF Community Housing accreditation or CARF Brain Injury Residential Rehabilitation Program (Adult) accreditation

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider Agreement;
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
- Comply with 42 CFR §441.301(c)(4) and (5) specific to allowable settings for home and community-based waiver services;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a waiver service location in Pennsylvania;
- Have Commercial General Liability Insurance
- Have Professional Liability Errors and Omissions Insurance
- Have Workers Compensation Insurance in accordance with state statute and in accordance with Departmental policies
- Ensure that employees have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs.

Individuals employed to provide Residential Habilitation services must:

Be at least 18 years of age;

- Have a high school diploma or GED;
- Have a minimum of six months of paid or volunteer experience working with people with disabilities.
- Comply with Department standards including regulations, policies and procedures related to provider qualifications;
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
- Complete Initial Residential Habilitation Service Training within 6 months of being hired, which consists of a minimum of 12 hours of brain injury specific training.
- Complete a minimum of 12 hours of Ongoing Residential Habilitation Training annually which directly relates to job responsibilities.
- Staff who are employed to provide Enhanced Residential Habilitation Services must also have initial training in behavioral programming and crisis prevention which must be renewed annually.
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
- Agree to carry out the Residential Habilitation outcomes included in the participant's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021 in accordance with the Good Faith Exemption granted by the Centers for Medicare and Medicaid Services and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

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

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

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

Individuals are authorized for up to 14 consecutive days in an institutional facility. However, this may be increased up to 29 consecutive days, based on need and with the prior approval of the CHC-MCO.

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

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

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

Participant-directed as specified in Appendix E

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 Care Agency
Agency	Medicaid Certified Nursing Facility
Individual	Individual Respite Worker
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License (*specify*):

Licensed by the PA Department of Health, per 28 PA Code Chapter 611 (Home Care Agencies and Home Care Registries)

Certificate (*specify*):

N/A

Other Standard (specify):**Agency:**

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

Individuals working for agencies must meet the following standards:

- Be 18 years of age or older;
- Possess basic math, reading and writing skills;
- Complete training or demonstrate competency by passing a competency test as outlined in Section 611.55 under Title 28, Part IV Subpart H of the Health Care Facilities Act;
- Have the required skills to perform services as specified in the participant's service plan;
- Complete any necessary pre/in-service training related to the participant's service plan;
- Agree to carry-out outcomes included in the participant's service plan;
- Possess a valid Social Security number;
- Must pass criminal records check as required in 55PA Code Chapter 52 Section 52.19;
- Have a child abuse clearance as required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

Medicaid Certified Nursing Facility

Provider Qualifications**License (specify):**

Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities Subpart A Chapter 51, and Subpart B. Chapter 201.

Certificate (*specify*):

Certification as required by specific profession or discipline, per 42CFR Part 484

Other Standard (*specify*):

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Individual Respite Worker

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

N/A

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Be 18 years of age or older;
- Possess basic math, reading, and writing skills;
- Possess a valid Social Security number;
- Submit to a criminal record check;
- Have a child abuse clearance as required in Appendix C-2-b;
- Have the required skills to perform Respite Services as specified in the participant's service plan;
- Complete any necessary pre/in-service training related to the participant's service plan;
- Agree to carry-out outcomes included in the participant's service plan; and
- Be able to demonstrate the capability to perform health maintenance activities specified in the participant's service plan or receive necessary training.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

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

Certificate (specify):

Certification as required by 42CFR Part 484

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
 - Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
 - Have Commercial General Liability insurance and
 - Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age;
 - Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
 - Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
 - Have a child abuse clearance as required in Appendix C-2-b;
 - Be supervised by a registered nurse;
 - Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
 - Successfully completed a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e), or a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e).

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Structured Day Habilitation Services

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

04 Day Services

04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

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

Staff to Client Ratios

- One direct care staff to 8 clients during activities
- One other individual must always be present

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

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

Enhanced Structured Day Habilitation Staffing may be provided at the following levels:

- Level 1: staff-to-individual ratio of 1:1.
- Level 2: staff-to-individual ratio of 2:1 or greater.

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

Billing for Structured Day Habilitation:

Structured Day Habilitation Services do not include: 1:1 therapies (OT, PT, ST, Cognitive Rehabilitation Therapy, and Behavior Therapy), adult daily living, employment skills development, job coaching, personal assistance services or community integration. These services are available to participants receiving Structured Day Habilitation Services as indicated in the needs assessment and documented on the Person-Centered Service Plan, but may not be provided simultaneously. Structured Day Habilitation Services also do not include competitive employment or higher education courses. Structured Day Habilitation Services may not provide for the payment of services that are vocational in nature and for the primary purpose of producing goods or performing services.

Transportation can be included as a separate service as indicated on the needs assessment and documented on the PCSP for participants that are not also receiving Residential Habilitation Services.

The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's Person-Centered Service Plan.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Structured Day Habilitation Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Structured Day Habilitation Services

Provider Category:

Agency

Provider Type:

Structured Day Habilitation Agency

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

CARF Community Integration accreditation, or CARF Brain Injury Home and Community Services (Adult) accreditation, or be licensed under 55 Pa Code, Chapter 2380 as an Adult Training Facility.

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver Provider Agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
- Comply with 42 CFR §441.301(c)(4) and (5) specific to allowable settings for home and community-based waiver services;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
- Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
- Have Commercial General Liability Insurance
- Have Professional Liability Errors and Omissions Insurance
- Have Worker's Compensation Insurance in accordance with State statute and in accordance with Department policies.
- Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavior needs.
- Necessary staff, may include independent education instructors, speech therapists, physical therapists, occupational therapists, behavior therapists or cognitive rehabilitation therapists or other staff, to meet participant needs as outlined in the participant's service plan.

All individuals working for or contracted with agencies must meet the following standards:

- Be at least 18 years of age
- Comply with all Department standards including regulations, policies and procedures related to provider qualifications
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavior needs
- Complete initial Structured Day Habilitation Service Training within 6 months of being hired, which consists of a minimum of 20 hours of brain injury specific training.
- Complete a minimum of 12 hours of Ongoing Structured Day Habilitation Training annually.
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

In addition to the general standards listed above, Individual Support Staff must:

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

In addition to the general standards listed above, Independent Education Instructors must:

- Hold a Bachelor's degree with a current teaching certificate
- Have two years of experience teaching basic adult education
- Be certified under the Department of Education

Develop and implement goals for the day treatment program plan, and document and record progress of individuals served.

In addition to the general standards listed above, Cognitive Rehabilitation Therapists must:

- Be a licensed Occupational Therapist under the PA Department of State, per 49 PA Code Chapter 42, including 42.22 pertaining to assistants (Occupational Therapy and Education Licensing Board) or
- Be a licensed psychologist licensed by the State Board of Psychology Professional Psychologists Practice Act, 63 P.S. §§ 1201-1218, per 49 PA Code Chapter 41 or
- Be a licensed social worker licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49 or

- Be a licensed professional counselor licensed by the state of Pennsylvania as a Professional Counselor with a Master's degree or a doctorate from a CACREP-approved academic program, passed the National Counselor Examination (NCE), and completed at least 3 years or 3,600 hours of supervised clinical experience or
- Be a licensed Speech and Language Therapist licensed under the PA Department of State, per 49 PA Code Chapter 45 (Language and Hearing Examiner's Board).
- Individuals with a bachelor's or master's degree in an allied rehabilitation field as defined by the Society for Cognitive Rehabilitation who are not licensed or certified may practice under the supervision of a practitioner who is licensed as listed above

In addition to the general standards listed above, Speech Therapists must:

- Be licensed under the PA Department of State, per 49 PA Code Chapter 45 (Language and Hearing Examiner's Board)
- Have certification as required by 42CFR Part 484
- Develop and implement goals for the day treatment program plan, and document and record progress of individuals served.

In addition to the general standards listed above, Occupational Therapists or Occupational Therapy Assistants must:

- Be licensed under the PA Department of State, per 49 PA Code Chapter 42, including 42.22 pertaining to assistants (Occupational Therapy and Education Licensing Board)
- Have certification as required by 42 CFR Part 484
- Develop and implement goals for the day treatment program plan, and document and record progress of individuals served.

In addition to the general standards listed above, Physical Therapists or Physical Therapy Assistants must:

- Be licensed under PA Department of State, per 49 PA Code Chapter 40 (Physical Therapy Licensing Board)
- Have certification as required by 42CFR Part 484
- Develop and implement goals for the day treatment program plan, and document and record progress of individuals served.

In addition to the general standards listed above, professionals providing Behavior Therapy must :

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

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Counseling Services

HCBS Taxonomy:
Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10060 counseling

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):**
Category 4:**Sub-Category 4:**

Counseling Services are services that assist individuals to improve functioning and independence and are necessary to improve the individual's inclusion in their community. The service may include assessing the individual, developing a home support plan, providing ongoing counseling, training family members/staff, providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

Counseling services are non-medical counseling services provided to participants in order to resolve individual or social conflicts and family issues such as assisting the individual to develop and maintain positive support networks, how to improve personal relationships, or how to improve communication with family members or others. While counseling services may include family members, the counseling must be on behalf of the participant and documented in his/her service plan. Counseling for unpaid caregivers must be aimed at assisting the unpaid caregiver in understanding and meeting the needs of the participant and be documented in his/her service plan.

Services are provided by a licensed psychologist, licensed social worker, licensed professional counselor, or a home health agency that employs them.

Counseling Services do not include group counseling serving multiple participants.

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

Mental Health and Drug and Alcohol Counseling Services are available under the Medicaid State Plan for individuals who have a mental health or substance abuse diagnosis. The State Plan has additional provider types for Mental Health Counseling compared to Counseling Services under the CHC Waiver. Drug and Alcohol Counseling under the State Plan requires providers to have competency in the area of chemical dependency, which is not a requirement for Counseling Services in the CHC Waiver.

Participants must access State Plan services, including Outpatient Psychiatric Clinic Services, Outpatient Drug and Alcohol Services and services through the Behavioral Health Managed Care Organizations before accessing Counseling Services through the CHC Waiver. Counseling Services are accessible through the CHC Waiver only when a mental health or substance abuse diagnosis is not present or the services under the State Plan are deemed to not be medically necessary.

In addition, Counseling Services may only be funded through the waiver when the service is not covered by a responsible third party, such as Medicare or private insurance. This may be because the Medicare or insurance limitations have been reached, or the service is not covered, or the provider does not have the expertise or experience specific to the disability.

The Service Coordinator is responsible for verifying and documenting in the participant's file that the participant does not qualify for Medicaid State Plan services and/or that Medicare and private insurance limitations have been exhausted. Documentation must be maintained in the individual's file by the Service Coordinator. This documentation must be updated annually.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Professional Counselor
Individual	Licensed Psychologist
Individual	Licensed Social Worker
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Counseling Services

Provider Category:

Individual

Provider Type:

Licensed Professional Counselor

Provider Qualifications

License (specify):

Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49

Certificate (specify):

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
- Have a child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Extended State Plan Service

Service Name: Counseling Services

Provider Category:

Individual

Provider Type:

Licensed Psychologist

Provider Qualifications**License (specify):**

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

Certificate (specify):

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
- Have a child abuse clearance as required in Appendix C-2-b; and
- Comply with all Department standards related to provider qualifications.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Counseling Services****Provider Category:**

Individual

Provider Type:

Licensed Social Worker

Provider Qualifications**License (specify):**

Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49

Certificate (specify):**Other Standard (specify):**

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
- Have a child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Extended State Plan Service

Service Name: Counseling Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

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

Certificate (specify):

Certification as required by 42CFR Part 484

Other Standard (specify):

Agency:

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

Individuals working for or contracted with agencies must meet the following standards:

- Be 18 years of age or older;
- Possess basic math, reading and writing skills;
- Complete training or demonstrate competency by passing a competency test as outlined in Section 601.33 and 601.34 under Title 28, Part IV Subpart G 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 required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Extended State Plan Service

Service Title:

Home Health Aide Services

HCBS Taxonomy:**Category 1:**

11 Other Health and Therapeutic Services

Sub-Category 1:

11010 health monitoring

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Home Health Aide services are direct services prescribed by a physician, a nurse practitioner or physician assistant in addition to any services furnished under the State Plan that are necessary, as specified by the service plan, to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The physician's, nurse practitioner's or physician assistant's order must be obtained every sixty (60) days for continuation of service. The home health aide provider is responsible for reporting, to the ordering physician, nurse practitioner or physician assistant and Service Coordinator, changes in the participant's status that take place after the prescriber's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Nursing services authorized in the service plan.

Home Health Aide services are provided by a home health aide who is supervised by a registered nurse. The registered nurse supervisor must reassess the participant's situation in accordance with 55 PA Code Chapter 1249, §1249.54. Home Health Aide activities include, personal care, performing simple measurements and tests to monitor a participant's medical condition, assisting with ambulation, assisting with other medical equipment and assisting with exercises taught by a registered nurse, licensed practical nurse or licensed physical therapist

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

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

Home Health Aide services are provided under the waiver when the limits of the State Plan service under the approved State Plan are exhausted and the scope/nature of these service do not otherwise differ from the services furnished under the State Plan. The approved State Plan includes limits on the number of days per month the service can be provided. The provider qualifications in the waiver are the same qualifications specified in the State Plan.

In addition, Home Health Aide services may only be funded through the waiver when the services are not covered by Medicare or private insurance. This may be because Medicare or private insurance limitations have been reached, or the service is not covered under Medicare or private insurance.

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

Home Health Care Aide services cannot be provided simultaneously with Personal Assistance Services, Adult Daily Living Services, or Respite Services.

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

The most appropriate level of staffing, as determined by the assessment, must be used for a task.

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

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	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Home Health Aide Services

Provider Category:

Individual

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Certification as required by 42CFR Part 484

Other Standard (*specify*):

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

Individuals working for agencies must meet the following standards:

- Be at least 18 years of age;
- Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
- Have a child abuse clearance as required in Appendix C-2-b;
- Be supervised by a registered nurse;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
- Shall meet the requirements of 28 PA Code §601.35 specific to home health aide services.

Successfully completed a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e).

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Nursing Services

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05020 skilled nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

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

- Short-term or Intermittent Nursing — Nursing that is provided on a short-term or intermittent basis, not expected to exceed 75 units of service in a service plan year and are over and above services available to the participant through the State Plan
- Long-term or Continuous Nursing — Long-term or continuous nursing is needed to meet ongoing assessed needs that are likely to require services in excess of 75 units per service plan year, are provided on a regular basis and are over and above services available to the participant through the State Plan

The nurse is responsible for reporting, to the ordering physician, nurse practitioner or physician assistant and Service Coordinator, changes in the participant's status that take place after the prescriber's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Nursing services authorized in the service plan

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

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

Nursing services are provided under the waiver when the limits of the State Plan service under the approved State Plan are exhausted, and the scope/nature of these service do not otherwise differ from the services furnished under the state plan. The approved State Plan includes limits on the number of days per month the service can be provided. Long-term or Continuous Nursing services are not covered by the State Plan for adults. The provider qualifications in the waiver are the same qualifications specified in the State Plan.

In addition, nursing services may only be funded through the waiver when the services are not covered by Medicare or private insurance. This may be because Medicare or private insurance limitations have been reached, or the service is not covered under Medicare or private insurance.

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

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

Long-term or continuous nursing cannot be provided simultaneously with Personal Assistance Services, Adult Daily Living Services, Residential Habilitation Services or Respite Services. Short-term or intermittent nursing can be provided simultaneously with Residential Habilitation Services. The CHC-MCO may consider an exception to the limitation on long-term or continuous nursing and Residential Habilitation Services with documentation from the Service Coordinator that supports the participant's need to receive both services.

The most appropriate level of staffing, as determined by the assessment, must be used for a task.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Nursing Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Certification as required by 42CFR Part 484

Other Standard (*specify*):

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

Individuals working for agencies must meet the following standards:

- Be at least 18 years of age;
- Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
- Have a child abuse clearance as required in Appendix C-2-b;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
- Shall meet the requirements of 28 PA Code §601.32 specific to nursing services. Successfully completed a State-established or other training program that meets the requirements of 49 PA Code Chapter 21 and a State licensure program that meets the requirements of Sec. 49 PA Code Chapter 21.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy Services

HCBS Taxonomy:**Category 1:**

11 Other Health and Therapeutic Services

Sub-Category 1:

11080 occupational therapy

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

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

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

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

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

Services must be provided at a 1:1 ratio.

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

Occupational Therapy services are provided under the waiver when the limits of the State Plan service under the approved State Plan are exhausted and the scope/nature of these service do not otherwise differ from the services furnished under the state plan. The approved State Plan includes limits on the number of days per month the service can be provided. The provider qualifications in the waiver differ from the qualifications specified in the State Plan. The waiver includes additional provider types not specified in the State Plan.

In addition, Occupational Therapy services may only be funded through the waiver when the services are not covered by Medicare or private insurance. This may be because Medicare or private insurance limitations have been reached, or the service is not covered under Medicare or private insurance.

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

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

The most appropriate level of staffing, as determined by the assessment, must be used for a task.

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Occupational Therapy Services

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License (specify):

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

Certificate (specify):

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
- Have a child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Extended State Plan Service

Service Name: Occupational Therapy Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License** (*specify*):

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

Certificate (*specify*):

Certification as required by 42CFR Part 484

Other Standard (*specify*):

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

Individuals working for agencies must meet the following standards:

- Be at least 18 years of age;
- Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
- Have a child abuse clearance as required in Appendix C-2-b;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
- Successfully completed a State-established or other training program that meets the requirements of 49 PA Code Chapter 42 and a State licensure program that meets the requirements of 49 PA Code Chapter 42.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Occupational Therapy Services

Provider Category:

Agency

Provider Type:

Out-Patient or Community-Based Rehabilitation Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Medicare Certification by PA Department of Health as required by 42CFR 485.701 through 485.729

Other Standard (*specify*):

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

Individuals working for agencies must meet the following standards:

- Be at least 18 years of age;
- Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Successfully completed a State-established or other training program that meets the requirements of 49 PA Code Chapter 42 and a State licensure program that meets the requirements of 49 PA Code Chapter 42;
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
- Must hold an appropriate active license in the State of Pennsylvania;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
- Have a child abuse clearance as required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy Services

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11090 physical therapy

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

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

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

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

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

Services must be provided at a 1:1 ratio.

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

Physical Therapy services are provided under the waiver when the limits of the State Plan service under the approved State Plan are exhausted and the scope/nature of these service do not otherwise differ from the services furnished under the state plan. The approved State Plan includes limits on the number of days per month the service can be provided. The provider qualifications in the waiver differ from the qualifications specified in the State Plan. The waiver includes additional provider types not specified in the State Plan.

In addition, Physical Therapy services may only be funded through the waiver when the services are not covered by Medicare or private insurance. This may be because Medicare or private insurance limitations have been reached, or the service is not covered under Medicare or private insurance.

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

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

The most appropriate level of staffing, as determined by the assessment, must be used for a task.

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Physical Therapy Services

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License (specify):

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

Certificate (specify):

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
- Have a child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Extended State Plan Service

Service Name: Physical Therapy Services

Provider Category:

Agency

Provider Type:

Out-Patient or Community-Based Rehabilitation Agency

Provider Qualifications**License** (*specify*):
Certificate (*specify*):

Medicare Certification by PA Department of Health as required by 42CFR 485.701 through 485.729

Other Standard (*specify*):

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

Individuals working for agencies must meet the following standards:

- Be at least 18 years of age;
- Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Successfully completed a State-established or other training program that meets the requirements of 49 PA Code Chapter 40 and a State licensure program that meets the requirements of 49 PA Code Chapter 40;
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
- Must hold an appropriate active license in the State of Pennsylvania;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
- Have a child abuse clearance as required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Physical Therapy Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Certification as required by 42CFR Part 484

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
 - Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
 - Have Commercial General Liability insurance; and
 - Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
- Individuals working for agencies must meet the following standards:
- Be at least 18 years of age;
 - Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
 - Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
 - Have a child abuse clearance as required in Appendix C-2-b;
 - Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
 - Successfully completed a State-established or other training program that meets the requirements of 49 PA Code Chapter 40 and a State licensure program that meets the requirements of 49 PA Code Chapter 40.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

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

14 Equipment, Technology, and Modifications

14032 supplies

Category 3:**Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

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

Specialized Medical Equipment and Supplies includes:

- Devices, controls or appliances, specified in the service plan, that enable participants to increase, maintain or improve their ability to perform activities of daily living
- Equipment repair and maintenance, unless covered by the manufacturer warranty
- Items that exceed the limits set for Medicaid State plan covered services
- Rental Equipment. In certain circumstances, needs for equipment or supplies may be time limited. The Service Coordinator must initially verify that the rental costs cannot be covered by the State Plan. If the State Plan does not cover the rental for the particular piece of equipment needed, then the cost of the rental can be funded through Specialized Medical Equipment and Supplies
- Personal Protective Equipment (PPE) such as gloves, gowns and masks for participant and informal support/unpaid caregiver use, as long as the PPE is used to deliver care to the participant, can be obtained under Specialized Medical Equipment and Supplies. PPE may be added to a participant's PCSP without the need for a physician's prescription. This does not supplant the Occupational Safety and Health Administration (OSHA) requirements under 29 CFR §1910.132 for agencies to provide PPE to their workers.

Non-Covered Items:

- All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream)
- Items covered under third party payer liability
- Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's disability
- Food, food supplements, food substitutes (including formulas), and thickening agents;
- Eyeglasses, frames, and lenses;
- Dentures
- Any item labeled as experimental that has been denied by Medicare and/or Medicaid
- Recreational or exercise equipment and adaptive devices for such.

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

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

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

Specialized Medical Equipment and Supplies services are provided when the limits of the State Plan service under the approved State Plan are exhausted and the scope/nature of these service do not otherwise differ from the services furnished under the state plan. The approved State Plan includes requirements for prior authorization on items above a specific cost and includes limitations for oxygen and related equipment. The provider qualifications in the waiver differ from the qualifications specified in the State Plan. The waiver includes additional provider types not specified in the State Plan.

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

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

Hearing Aids require, but this service does not cover, an evaluation conducted by a physician certified by the American Board of Otolaryngology (ear, nose, and throat physician). Hearing aids must be purchased and fitted by a Pennsylvania registered hearing aid fitter, licensed audiologist, or licensed physician associated with a registered hearing aid dealer.

Hearing aid purchases are limited to once every three years.

Specialized Medical Equipment and Supplies exclude Assistive Technology.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacy
Agency	Hearing Aid Dealer
Agency	Durable Medical Equipment

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:

Provider Qualifications**License** (*specify*):
Certificate (*specify*):
Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
 - Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
 - Have Commercial General Liability insurance
 - Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
 - Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age
 - Comply with all Department standards including regulations, policies and procedures related to provider qualifications
 - Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
 - Have a child abuse clearance as required in Appendix C-2-b
 - 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:**

Frequency of Verification:

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Hearing Aid Dealer

Provider Qualifications**License** (*specify*):

N/A

Certificate (*specify*):

Certified by the PA Department of Health under 28 Pa. Code Ch. 25, SubChapter B Hearing Aid Sales and Registration

Other Standard (*specify*):

- Employ a licensed physician, licensed audiologist, or registered hearing aid fitter qualified by PA Department of Health to sell and fit hearing aids
 - Comply with 55 PA Code 1101 and have a waiver provider agreement
 - Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
 - Have Commercial General Liability insurance
 - Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
 - Meet enrolled provider participation requirements as described in Chapter 1101 Medical Assistance Provider participation requirement
 - Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age
 - Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
 - Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility, and behavioral needs
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
 - Have a child abuse clearance as required in Appendix C-2-b
 - 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

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

Provider Category:

Agency

Provider Type:

Durable Medical Equipment

Provider Qualifications**License** (*specify*):

N/A

Certificate (*specify*):

Drug and Device Registration with the PA Department of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
 - Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
 - Have Commercial General Liability insurance
 - Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
 - Meet enrolled provider participation requirements as described in Chapter 1101 Medical Assistance Provider participation requirement
 - Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies
 - Assessment performed as necessary by a Certified Assistive Technology Professional with certification in good standing. Assistive Technology Professionals must be a graduate of a Department approved Rehabilitation Science program that is certified by RESNA, the Rehabilitation Engineering and Assistive Technology Society of North America; or have a degree in Rehabilitation Science, as defined by RESNA, with at least one year in evaluation and assessment of assistive technology needs for individuals with disabilities.
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age
 - Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
 - Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility, and behavioral needs
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
 - Have a child abuse clearance (as per 23 PA C.S. Chapter 63)
 - Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:**Service Title:****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

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

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

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

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

Services must be provided at a 1:1 ratio.

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

Speech and Language Therapy services are provided when the limits of the State Plan service under the approved State Plan are exhausted and the scope/nature of these service do not otherwise differ from the services furnished under the State Plan. The approved State Plan includes limits on the number of days per month the service can be provided. The provider qualifications in the waiver differ from the qualifications specified in the State Plan. The waiver includes additional provider types not specified in the State Plan.

In addition, Speech and Language Therapy services may only be funded through the waiver when the services are not covered by Medicare or private insurance. This may be because Medicare or private insurance limitations have been reached, or the service is not covered under Medicare or private insurance.

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

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

The most appropriate level of staffing, as determined by the assessment, must be used for a task.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian**Provider Specifications:**

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

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Speech and Language Therapy Services****Provider Category:**

Individual

Provider Type:

Speech Therapist

Provider Qualifications**License** (*specify*):

Licensed under the PA Department of State, per 49 PA Code Chapter 45 (Language and Hearing Examiner's Board)

Certificate (*specify*):**Other Standard** (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
- Have a child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Speech and Language Therapy Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Certification as required by 42CFR Part 484

Other Standard (*specify*):

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

Individuals working for agencies must meet the following standards:

- Be at least 18 years of age;
- Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
- Have a child abuse clearance as required in Appendix C-2-b;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service; and
- Successfully completed a State-established or other training program that meets the requirements of 49 PA Code Chapter 45 and a State licensure program that meets the requirements of 49 PA Code Chapter 45.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Speech and Language Therapy Services****Provider Category:**

Agency

Provider Type:

Out-Patient or Community-Based Rehabilitation Agency

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

Medicare Certification by PA Department of Health as required by 42CFR 485.701 through 485.729

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
 - Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
 - Have Commercial General Liability insurance; and
 - Ensure that employees have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
- Individuals working for agencies must meet the following standards:
- Be at least 18 years of age;
 - Comply with all Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
 - Successfully completed a State-established or other training program that meets the requirements of 49 PA Code Chapter 45 and a State licensure program that meets the requirements of 49 PA Code Chapter 45;
 - Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
 - Must hold an appropriate active license in the State of Pennsylvania;
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
 - Have a child abuse clearance as required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Assistive Technology consists of devices and services which are intended to ensure the health, welfare, independence and safety of the participant and to increase, maintain or improve a participant's functioning in communication, self-help, self-direction, life supports or adaptive capabilities.

An Assistive Technology device is an item, piece of equipment or product system — whether acquired commercially, modified or customized — that is needed by the participant, as specified in the participant's person-centered service plan (PCSP) and determined necessary in accordance with the participant's assessment. Assistive Technology is intended to ensure the health, welfare, independence or safety of the participant and to increase, maintain or improve a participant's functioning in communication, self-help, self-direction, life supports or adaptive capabilities.

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

Assistive Technology is limited to:

- Purchasing, leasing or otherwise providing for the acquisition of Assistive Technology devices for participants;
- Selecting, designing, fitting, connecting, customizing, adapting, applying, maintaining, installing, programming, repairing or replacing Assistive Technology devices. Repairs are covered when it is more cost effective than purchasing a new device and the device or repairs are not covered under a warranty;
- Electronic systems that enable a participant with functional limitations and identified needs to control various appliances, lights, telephone, doors and security systems in their room, home or other surroundings;
- Electronic devices that assist a participant with communication or prompting needs such as tablets, computers and electronic communication aids;
- Training or technical assistance for the participant, or where appropriate, the participant's family members, paid caregivers and informal supports on the use of assistive technology;
- An independent evaluation of the Assistive Technology needs of a participant. This includes a functional evaluation of the Assistive Technology needs and appropriate services for the participant in his/her customary environment;
- Extended warranties;
- Ancillary supplies, software, mobile apps, hubs and equipment necessary for the proper functioning of Assistive Technology devices, such as replacement batteries and materials necessary to adapt low-tech devices. This includes applications for electronic devices that assist participants with a communication or prompting need identified through the independent evaluation or physician's prescription described below; and
- Generators to power life-sustaining equipment are covered for participants residing in private homes when the following has been documented: The generator purchased is the most cost-effective to ensure the health and safety of the participant; AND the participant's health and safety is dependent upon electricity as documented by a physician.

All items purchased through Assistive Technology shall meet the applicable standards of manufacture, design and installation.

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

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

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

This service excludes those items that are not of direct medical or remedial benefit to the participant or are primarily for a recreational or diversionary nature. Items designed for general use shall only be covered to the extent necessary to meet the participant's needs as identified through the independent evaluation or physician's prescription described below and be for the primary use of the participant.

Assistive Technology devices must be recommended by an independent evaluation or physician's prescription. They will only be approved by the CHC-MCO when there is sufficient documentation in the independent evaluation or physician's prescription that specifies the item is used to ensure the health, welfare, independence or safety of the participant and serves as a less costly alternative than other suitable devices and alternative methods.

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

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

This service does not include TeleCare services. Data plans are excluded from coverage.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Contractor
Agency	Durable Medical Equipment
Agency	Equipment, technology and modifications agency or specialist

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Contractor

Provider Qualifications**License** (*specify*):

N/A

Certificate (*specify*):

N/A

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
- Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania (A company that the provider secures the item(s) from can be located anywhere)
- Adhere to all applicable local and State codes
- Have Commercial General Liability Insurance
- Have Workers Compensation Insurance, in accordance with State statute

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Assistive Technology**Provider Category:**

Agency

Provider Type:

Durable Medical Equipment

Provider Qualifications**License** (*specify*):

N/A

Certificate (*specify*):

Drug and Device Registration with the PA Dept of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25.

Other Standard (*specify*):

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

Individuals working for or contracted with agencies must meet the following standards:

- Be at least 18 years of age
- Comply with all Department standards including regulations, policies and procedures related to provider qualifications
- 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 required in Appendix C-2-b
- 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Equipment, technology and modifications agency or specialist

Provider Qualifications

License (*specify*):

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Certificate (*specify*):

--

Other Standard (*specify*):

<ul style="list-style-type: none"> • Comply with 55 PA Code 1101 and have a waiver provider agreement • Comply with Department standards, including regulations, policies and procedures relating to provider qualifications • Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies • Have Commercial General Liability insurance • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs • Meet enrolled provider participation requirements as described in Chapter 1101 Medical Assistance Provider participation requirement • Assessment performed by a Certified Assistive Technology Professional with certification in good standing. Assistive Technology Professionals must be a graduate of a Department approved Rehabilitation Science program that is certified by RESNA, the Rehabilitation Engineering and Assistive Technology Society of North America; or have a degree in Rehabilitation Science, as defined by RESNA, with at least one year in evaluation and assessment of assistive technology needs for individuals with disabilities. <p>Individuals working for or contracted with agencies must meet the following standards:</p> <ul style="list-style-type: none"> • Be at least 18 years of age • Comply with all Department standards including regulations, policies and procedures related to provider qualifications • Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs • Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15 • Have a child abuse clearance as required in Appendix C-2-b • 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.
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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:

Behavior Therapy

HCBS Taxonomy:**Category 1:**

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Behavior Therapy services are services that assist individuals to improve functioning and independence and are necessary to improve the individual's inclusion in their community. Services include the completion of a functional behavioral assessment; the development of an individualized, comprehensive behavioral support plan, and the provision of training to individuals, family members and direct service providers. Services include consultation, monitoring the implementation of the behavioral support plan and revising the plan as necessary. This service may be delivered in the individual's home or in the community as described in the service plan.

Behavior Therapy services are provided by professionals and/or paraprofessionals in behavior management, including a licensed psychologist, licensed social worker, licensed behavior specialist, licensed professional counselor, or a home health agency that employs them. Individuals with a master's degree in social work, psychology, education, counseling, or a related human services field who are not licensed or certified may practice under the supervision of a practitioner who is licensed.

Services must be provided at a 1:1 ratio.

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

Behavior Therapy Services are not covered for adults under the Medicaid State Plan; however, if there is a mental health or substance abuse diagnosis, including adjustment disorder, the State Plan offers other services to treat participants. Behavior Therapy Services are utilized through the CHC Waiver only when a mental health or substance abuse diagnosis is not present or the services available under the State Plan are not appropriate to treat the participant's condition. Participants must access State Plan services, including Outpatient Psychiatric Clinic Services, Outpatient Drug and Alcohol Services and services through the Behavioral Health Managed Care Organizations if the services are appropriate to treat the participant's condition before accessing Behavior Therapy services through the CHC Waiver.

In addition, Behavior Therapy Services may only be funded through the waiver when the service is not covered by a responsible third party, such as Medicare or private insurance. This may be because Medicare or insurance limitations have been reached, the service is not covered, or the provider does not have the expertise or experience specific to the disability.

The Service Coordinator is responsible for verifying and documenting in the participant's file that the participant does not qualify for or the services are not appropriate under the Medicaid State Plan and/or that Medicare and private insurance limitations have been exhausted. Documentation must be maintained in the individual's file by the Service Coordinator. This documentation must be updated annually.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Therapy

Provider Category:

Individual

Provider Type:

Licensed Social Worker

Provider Qualifications

License (*specify*):

Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49

Certificate (*specify*):

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
- Have a child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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: Behavior Therapy

Provider Category:

Individual

Provider Type:

Licensed Behavior Specialist

Provider Qualifications

License (*specify*):

Licensed by the State Board of Medicine, per 49 Pa, Code §§ 18.521 - 18.527

Certificate (*specify*):

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
- Have a child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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: Behavior Therapy

Provider Category:

Individual

Provider Type:

Licensed Professional Counselor

Provider Qualifications**License (specify):**

Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49

Certificate (specify):**Other Standard (specify):**

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
- Have a child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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: Behavior Therapy

Provider Category:

Individual

Provider Type:

Licensed Psychologist

Provider Qualifications**License (specify):**

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

Certificate (specify):**Other Standard (specify):**

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
- Have a child abuse clearance as required in Appendix C-2-b; and
- Comply with all Department standards related to provider qualifications.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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: Behavior Therapy

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

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

Certificate (specify):

Certification as required by 42CFR Part 484

Other Standard (specify):

Agency:

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

Individuals working for or contracted with agencies must meet the following standards:

- Be 18 years of age or older;
- Possess basic math, reading and writing skills;
- Complete training or demonstrate competency by passing a competency test as outlined in Section 601.34 under Title 28, Part IV Subpart G 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 required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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:

Benefits Counseling

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Benefits Counseling is a service designed to inform, and answer questions from, a participant about competitive integrated employment and how and whether it will result in increased economic self-sufficiency and/or net financial benefit through the use of various work incentives. This service provides an accurate, individualized assessment. The service provides information to the individual regarding the full array of available work incentives for essential benefit programs including SSI, SSDI, Medicaid, Medicare, housing subsidies, SNAP, etc.

The service also will provide information and education to the participant regarding income reporting requirements for public benefit programs, including the Social Security Administration.

Benefits counseling provides work incentives counseling and planning services to persons actively considering or seeking competitive integrated employment or career advancement.

Service must be provided in a manner that supports the person's communication style and needs.

Benefits Counseling services are paid for on an hourly basis and limited in the following ways:

- a. Initial Benefits Counseling for someone actively considering or seeking individualized integrated employment or self-employment, or career advancement in these types of employment: up to twenty (20) hours. This service may be authorized no more than once every two (2) years (with a minimum of two 365-day intervals between services).
- b. Supplementary Benefits Counseling for a participant evaluating a job offer/promotion or self-employment opportunity: up to an additional six (6) hours.
- c. Problem-Solving services for a participant to maintain competitive integrated employment: up to eight (8) hours per situation. This service may be authorized up to four (4) times per year if necessary for the individual to maintain individualized integrated employment or self-employment.

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

Benefits Counseling may not be rendered under the waiver to a participant under a program funded by either the Rehabilitation Act of 1973 as amended or any other small business development resource available to the participant.

Benefits Counseling may only be provided if it is documented in the service plan that Benefits Counseling services provided by a Certified Work Incentives Counselor through a Pennsylvania-based federal Work Incentives Planning and Assistance (WIPA) program were sought and it was determined that such services were not available either because of ineligibility or because of wait lists that would result in services not being available within 30 calendar days.

Documentation in accordance with Department requirements must be maintained in the file by the Service Coordinator and updated with each reauthorization to satisfy the State assurance that the service is not otherwise available to the participant under other federal programs.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Benefits Counseling Agency
Individual	Benefits Counselor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Benefits Counseling

Provider Category:

Agency

Provider Type:

Benefits Counseling Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used as a component of this service

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
- Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
- Have Commercial General Liability insurance
- Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs

Individuals working for or contracted with agencies must meet the following standards:

- Be at least 18 years of age
- Comply with all Department standards regarding 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 valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service

Individuals working directly with the participant to provide Benefits Counseling services shall hold the following:

- A Certified Work Incentives Counselor certification that is accepted by the Social Security Administration for its Work Incentives Planning and Assistance program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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: Benefits Counseling

Provider Category:

Individual

Provider Type:

Benefits Counselor

Provider Qualifications**License (specify):****Certificate (specify):**

Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used as a component of this service

A Certified Work Incentives Counselor certification that is accepted by the Social Security Administration for its Work Incentives Planning and Assistance program.

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
- Have Commercial General Liability insurance in accordance with Department policies
- Be at least 18 years of age
- Have a bachelor's degree and 1 year of documented related experience, or
- Have an associate's degree and 2 years of documented related experience, or
- Have a high school diploma or GED and at least 3 years of documented related experience
- 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

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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:

Career Assessment

HCBS Taxonomy:

Category 1:**Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Career Assessment is an individualized employment assessment used to assist in the identification of potential career options based upon the interests and strengths of the participant. Career Assessment services are necessary, as specified in the service plan, to support the participant to live and work successfully in home and community-based settings, enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age.

Career Assessment is an individualized employment assessment that includes:

- Conducting a review of the participant's work and volunteer history, interests and skills, which may include information gathering or interviewing;
- Conducting situational assessments to assess the participant's interest and aptitude in a particular type of job;
- Identifying types of jobs in the community that match the participant's interests, strengths and skills; and
- Developing a Career Assessment Report that specifies recommendations regarding the participant's needs, interests, strengths, and characteristics of potential work environments. The Career Assessment Report must also specify training or skills development necessary to achieve the participant's employment or career goals that could be addressed by other waiver services in the participant's service plan.

This service includes Discovery for individuals who due to the impact of their disability, their skills, preferences, and potential contributions cannot be best captured through traditional, standardized means, such as functional task assessments, situational assessments, and/or traditional normative assessments which compare the individual to others or arbitrary standards of performance and/or behavior. Discovery involves a comprehensive analysis of the person in relation to following:

- o Strongest interests toward one or more specific aspects of the labor market;
- o Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment;
- o Conditions necessary for successful employment or self-employment.

Discovery includes the following activities: observation of person in familiar places and activities, interviews with family, friends and others who know the person well, observation of the person in an unfamiliar place and activity, identification of the person's strong interests and existing strengths and skills that are transferable to individualized integrated employment or self-employment. Discovery also involves identification of conditions for success based on experience shared by the person and others who know the person well, and observation of the person during the Discovery process. The information developed through Discovery allows for activities of typical life to be translated into possibilities for individualized integrated employment or self-employment.

The service also includes transportation as an integral component, such as transportation to a situational assessment during the delivery of Career Assessment.

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.

If the participant receives Behavior Therapy services, this service includes implementation of the behavior support plan and, if necessary, the crisis support plan. The service includes collecting and recording the data necessary to support the review of the service plan, the behavior support plan and the crisis support plan, as appropriate.

Results of Career Assessment needs to be documented and incorporated into the participant's service plan and shared, as appropriate.

Career Assessment is provided on a 1:1 client to staff ratio.

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

Career Assessment services may not be rendered under the waiver to a participant under a program funded by the Rehabilitation Act of 1973 as amended or any other small business development resource available to the participant. This means that Career Assessment services may only be provided when documentation has been obtained that one of the following has occurred:

1. OVR has closed a case for the participant or has stopped providing services to the participant;
2. The participant was determined ineligible for OVR services; or
3. It has been determined that OVR services are not available. If OVR has not made an eligibility determination within 120 days of the referral being sent, then OVR services are considered to not be available to the participant.

In the event that OVR closes the order of selection, the following process will be followed until the closure is lifted:

1. A participant who has been referred to OVR but does not have an approved Individualized Plan for Employment (IPE) may receive Career Assessment.
2. A participant who has not been referred to OVR may receive Career Assessment without a referral to OVR.

Documentation in accordance with Department requirements must be maintained in the file by the Service Coordinator and updated with each reauthorization to satisfy the State assurance that the service is not otherwise available to the participant under other federal programs.

Career Assessment does not include supports to continue paid or volunteer work once it is obtained.

Career Assessment services may only occur once per service plan year; payment will be made in 15-minute units.

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.

Federal Financial Participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in Career Assessment services
- Payments that are passed through to users of Career Assessment 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	Career Assessment Provider
Agency	Career Assessment Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Career Assessment

Provider Category:

Individual

Provider Type:

Career Assessment Provider

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used as a component of this service.

See "Other Standard"

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
- Have Commercial General Liability insurance in accordance with Department policies
- Be at least 18 years of age
- Have a master's degree in vocational/career evaluation or another field with a logical relationship to the provision of the service, or
- Meet the qualifications for a Vocational Rehabilitation Counselor, as defined by the PA Department of Labor and Industry, Office of Vocational Rehabilitation; or
- Have a bachelor's degree in a field with a logical relationship to the provision of the service and 1 year of documented related experience, and
- One of the following within 18 months of employment:
 - Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE)
 - Been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.
- Individuals who meet the qualifications for Vocational Rehabilitation Counselors are exempt from this provision.
- Individuals without certification must be supervised by an individual holding the above certification until certification is achieved. Certification must be achieved within 18 months of employment.
- Required certification for any assessment/evaluation tools utilized
- 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

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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: Career Assessment

Provider Category:

Agency

Provider Type:

Career Assessment Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used as a component of this service

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
 - Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
 - Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
 - Have Commercial General Liability insurance
 - Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age
 - Have a master's degree in vocational/career evaluation or another field with a logical relationship to the provision of the service, or
 - Meet the qualifications for a Vocational Rehabilitation Counselor, as defined by the PA Department of Labor and Industry, Office of Vocational Rehabilitation; or
 - Have a bachelor's degree in a field with a logical relationship to the provision of the service and 1 year of documented related experience, and
 - One of the following within 18 months of employment:
 - Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE)
 - Been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.
 - Individuals who meet the qualifications for Vocational Rehabilitation Counselors are exempt from this provision.
 - Individuals without certification must be supervised by an individual holding the above certification until certification is achieved. Certification must be achieved within 18 months of employment.
 - Required certification for any assessment/evaluation tools utilized
 - Comply with all Department standards including regulations, policies and procedures related to provider qualifications
 - Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
 - Have a 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Cognitive Rehabilitation Therapy (CRT) services are a systematic, goal-oriented approach designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions.

Through CRT, the participant utilizes methods that aim to help make the most of existing cognitive functioning through various methods, including guided practice on tasks that reflect particular cognitive functions, development of skills to help identify distorted beliefs and thought patterns, and strategies for taking in new information, such as the use of memory aids and other assistive devices. The goal for the participant receiving CRT is to achieve an awareness of their cognitive limitations, strengths, and needs and acquire the awareness and skills in the use of functional compensations necessary to increase the quality of life and enhance their ability to live successfully in the community. CRT services do not pay for equipment. Depending on the participant's need, equipment may be provided under another waiver service, such as Assistive Technology.

This service may include consultation, ongoing counseling, coaching and cueing, training family members/staff, providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

Services are provided by a licensed occupational therapist, licensed psychologist, licensed social worker, licensed professional counselor, licensed speech and language therapist, or a home health agency that employs them. Individuals with a bachelor's or master's degree in an allied rehabilitation field as defined by the Society for Cognitive Rehabilitation who are not licensed or certified may practice under the supervision of a practitioner who is licensed as listed above.

An individual seeking CRT services is required to have a treatment plan developed by the provider. The plan must include the participant's goals, frequency and duration of service and must be submitted to the CHC-MCO. The participant's goals must be reviewed by the provider and progress submitted to the CHC-MCO quarterly.

Services must be provided at a 1:1 ratio.

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

Cognitive Rehabilitation Therapy is not a State Plan service. Services may only be funded through the waiver when the service is not covered by another responsible third party, such as Medicare or private insurance, unless the required expertise and experience specific to the disability is not available through another responsible third party. This may be because the Medicare or insurance limitations have been reached, or the service is not covered under Medicare or private insurance, or the provider does not have the expertise or experience specific to the disability.

The Service Coordinator is responsible for verifying and documenting in the participant's file that responsible third-party limitations have been exhausted or that the third-party provider does not have the expertise or experience specific to the disability prior to funding services through the waiver. Documentation must be maintained in the individual's file by the Service Coordinator. This documentation must be updated annually.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Psychologist
Individual	Occupational Therapist
Individual	Speech and Language Therapist
Individual	Licensed Professional Counselor
Agency	Home Health Agency
Individual	Licensed Social Worker

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Cognitive Rehabilitation Therapy Services

Provider Category:

Individual

Provider Type:

Licensed Psychologist

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

N/A

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
- Have a child abuse clearance as required in Appendix C-2-b; and
- Comply with all Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Cognitive Rehabilitation Therapy Services****Provider Category:**

Individual

Provider Type:

Occupational Therapist

Provider Qualifications**License** (*specify*):

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

Certificate (*specify*):**Other Standard** (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
- Have a child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Cognitive Rehabilitation Therapy Services****Provider Category:**

Individual

Provider Type:

Speech and Language Therapist

Provider Qualifications**License** (*specify*):

Licensed under the PA Department of State, per 49 PA Code Chapter 45 (Language and Hearing Examiner's Board)

Certificate (*specify*):**Other Standard** (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
- Have a child abuse clearance as required by Appendix C-2-b.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Cognitive Rehabilitation Therapy Services**Provider Category:**

Individual

Provider Type:

Licensed Professional Counselor

Provider Qualifications**License** (*specify*):

Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49

Certificate (*specify*):

N/A

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
- Have a child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Cognitive Rehabilitation Therapy Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Certification as required by 42CFR Part 484

Other Standard (*specify*):

Agency:

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

Individuals working for or contracted with agencies must meet the following standards:

- Be 18 years of age or older;
- Possess basic math, reading and writing skills;
- Complete training or demonstrate competency by passing a competency test as outlined in Section 611.85 under Title 28, Part IV Subpart H of the Health Care Facilities Act;
- Complete training or demonstrate competency by passing a competency test as outlined in Section 601.33 and 601.34 under Title 28, Part IV Subpart G 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 required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Cognitive Rehabilitation Therapy Services

Provider Category:

Individual

Provider Type:

Licensed Social Worker

Provider Qualifications

License (specify):

Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47, 48 and 49

Certificate (specify):

N/A

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
- Have a child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Integration

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04070 community integration

Category 2:

Sub-Category 2:

Category 3:**Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Community Integration is a short-term, goal-based support service designed to assist participants in acquiring, retaining, and improving self-help, communication, socialization and adaptive skills necessary to reside in the community. Community integration can include cueing and on-site modeling of behavior to assist the participant in developing maximum independent functioning in community living activities.

Community Integration is goal-based and situational to assist individuals in achieving maximum function during life-changing events such as a transition from a nursing facility, moving to a new community or from a parent's home, or a change in condition that requires new skill sets. Services and training must focus on specific skills and be related to the expected outcomes outlined in the participants service plan.

Community Integration goals must be reviewed and/or updated at least quarterly by the Service Coordinator in conjunction with the participant to assure that expected outcomes are met and the service plan is modified accordingly.

Services must be provided at a 1:1 ratio.

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

Community Integration cannot be billed simultaneously with Residential Habilitation, Structured Day Habilitation, Adult Daily Living Services, or Personal Assistance Services

Community Integration is reviewed quarterly to determine the progress of how the strategies utilized are affecting the participant's ability to independently complete tasks identified in the PCSP. If the individual can complete the task independently, then the goal and CI service should be removed from the PCSP. The length of service should not exceed thirteen (13) weeks on new plans.

If the participant has not reached the goal at the end of 13 weeks, then documentation of the justification for continued training on the desired outcome must be incorporated into the PCSP at the time of the quarterly review.

If the participant has not reached his/her CI goals by the end of twenty-six (26) weeks, the goals need to change or it is concluded that the individual will not independently complete the goal and the SC must assess for a more appropriate service to meet the individual's need.

Each distinct goal may not remain on the PCSP for more than twenty-six (26) weeks.

No more than 32 units per week for one CI goal will be approved in the PCSP. If the participant has multiple CI goals, no more than 48 units per week will be approved in the PCSP.

The CHC-MCO retains the discretion to 1) authorize CI for individuals who have not experienced a "life-changing event"; and 2) authorize more than 48 units (12 hours) of CI in one week for up to 21 hours per week and for periods longer than 26 weeks.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Integration Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Integration

Provider Category:

Agency

Provider Type:

Community Integration Agency

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

N/A

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement;
 - Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
 - Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
 - Have Commercial General Liability insurance;
 - Professional Liability Errors and Omissions Insurance, and
 - Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.
- Individuals working for or contracted with agencies must meet the following standards: Be 18 years of age or older;
- Have a high school diploma or GED
 - Have a minimum of six months of paid or volunteer experience in working with people with physical disabilities and/or older adults
 - Comply with all Department standards including regulations, policies and procedures related to provider qualifications
 - Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
 - Have the required skills to perform the Community Integration services specified in the participant's service plan;
 - Possess a valid Social Security number; and
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
 - Have child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition Services

HCBS Taxonomy:

Category 1:

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Community Transition Services are one-time expenses for individuals transitioning from an institution or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. 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 allowable expenses that may be incurred:

- Essential furnishings and initial supplies such as a bed, a table, chairs, window blinds, eating utensils, and food preparation items;
- Moving Expenses;
- Security deposits that are required to obtain or retain a lease on an apartment or home;
- Set-up fees or deposits for utility or service access, Examples – e.g. telephone, electricity, heating;
- Services necessary for the participant's health and safety such as one-time cleaning and allergen control.

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 PCSP development process, clearly identified in the service plan and the participant is unable to meet such expense, or when the service cannot be obtained from other resources.

Expenditures may not include ongoing payment for rent or mortgage expenses.

Community Transition Services do not include food, regular utility charges and/or household appliances or items that are intended for purely for diversion/recreational purposes.

Community Transition Services does not include pest eradication. Individuals receiving Community Transition Services who require pest eradication may obtain it through the Pest Eradication Service.

Community Transition Services are limited to the purchase of the specific items to facilitate transition and not the supports or activities provided by the service coordinator/transition coordinator to obtain the items. The CHC-MCO pays individual vendors, such as landlords, utility companies, service agencies, furniture stores, and other retail establishments for the identified items.

Community Transition Services include only those non-recurring set-up expenses incurred during the 180 consecutive days prior to discharge from a nursing facility or hospital or another provider-operated living arrangement to an apartment or home in a private residence where the person is directly responsible for his or her own living expenses.

Community Transition Services are limited to an aggregate of \$4,000 per participant, per lifetime, as tracked and pre-authorized by the CHC-MCO.

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

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	Independent Vendors, Landlords, Utility Companies, Retail Establishments

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 Vendors, Landlords, Utility Companies, Retail Establishments

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

- 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.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Adaptations

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

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

Category 3:**Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Home Adaptations are physical adaptations to the primary private residence of the participant, as specified in the participant's person-centered service plan (PCSP) and determined necessary in accordance with the participant's assessment, to ensure the health, welfare and safety of the participant, and enable the participant to function with greater independence in the home. This includes primary egress into and out of the home, facilitating personal hygiene, and the ability to access common shared areas within the home.

Home Adaptations consist of installation, repair, maintenance, permits, necessary inspections, and extended warranties for the adaptations.

Adaptations to a household are limited to the following:

- Ramps from street, sidewalk or house
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the health, welfare and safety of the participant
- Vertical lifts only when vertical lifts and installation are not covered under the MA State Plan
- Track lift systems. A track lift system involves the installation of a "track" in the ceiling for moving a participant with a disability from one location to another. (Note: Portable lift systems are not considered home adaptations and are covered by the MA State Plan or the Specialized Medical Equipment and Supplies service in this waiver.)
- Handrails and grab-bars in and around the home
- Accessible alerting systems for smoke/fire/carbon monoxide for participants with sensory impairments. Service Coordinators must first seek these types of alert systems from local municipalities and/or fire departments.
- Outside railing to safely access the home
- Widened doorways, landings and hallways
- Swing-clear and expandable offset door hinges
- Flush entries and leveled thresholds
- Slip resistant flooring
- Kitchen counter, sink, and other cabinet modifications (including brackets for appliances). These types of adaptations will be considered only when the participant will be preparing their own meals, or the adaptation reduces the participant's dependence upon another person.
- Bathroom adaptations for bathing, showering, toileting and personal care needs
- Stair gliders and stair lifts only when stair gliders, stair lifts and installation are not covered under the MA State Plan. A stair lift is a chair or platform that travels on a rail, installed to follow the slope and direction of a staircase, which allows a user to ride up and down stairs safely
- Raised electrical switches and sockets
- Other adaptations, subject to CHC-MCO approval, to address specific assessed needs as identified in the service plan

All adaptations to the home shall be provided in accordance with applicable state or local building codes. In addition, the contractor is responsible for ensuring the dwelling is structurally sound and can accommodate the proposed modification prior to commencing any modifications.

Home Adaptations shall meet standards of manufacture, design and installation.

Home Adaptations must be an item of modification that the family would not be expected to provide to a family member without a disability or specialized needs.

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

Wheelchair lifts, stair glides, ceiling lifts, and metal accessibility ramps are covered by the State Plan, along with installation of the equipment or appliance. Other home adaptations in this service specification are not covered in the State Plan. Home Adaptations may only be funded through the waiver when the services are not covered by a responsible third-party, such as Medicare or private insurance, and when all other payors and community resources have been exhausted. 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 OLTL requirements must be maintained in the participant's file by the Service Coordinator and updated with each authorization.

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

Depending on the complexity of the home adaptation, the independent evaluation by an occupational therapist or a physical therapist may be supplemented with an assessment by individuals holding the following certifications: Certified Environmental Access Consultant (C.E.A.C.), Certified Living in Place Professional (CLIPP) or Executive Certificate in Home Modifications. Assessors with these certifications must have at least two years of experience assessing home adaptations for older adults or individuals with disabilities.

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

Home adaptations must be obtained in the least expensive, most cost-effective manner. Adaptations will not be approved if the home is in foreclosure, delinquent tax status, is not structurally sound, or the adaptation presents a safety concern based on applicable state and local building codes. Rent-to-purchase vertical lifts and stair glides may be rented provided the rental cost does not exceed the purchase price. When long-term use by the participant is expected or when rental is anticipated to exceed the cost of purchase, the equipment will be purchased for the participant or a permanent home adaptation will be considered.

Building a new room that adds to the total square footage of the home is excluded, except as noted below. Specialized Medical Equipment and Supplies is excluded.

Also excluded are those adaptations or improvements to the home that are of general maintenance and upkeep and are not of direct medical or remedial benefit to the participant; this includes items that are not up to code. Adaptations that add to the total square footage of the home are excluded from this benefit, except when necessary for the addition of an accessible bathroom when the cost of adding the bathroom is less than retrofitting an existing bathroom. Service Coordinators are responsible for helping participants explore all other sources, such as homeowner's insurance, landlord/property owner's insurance, and community resources, when participants need assistance covering general maintenance and upkeep to the home.

Materials and equipment must be based on the participant's need as documented in the PCSP.

Adaptations at rental properties must meet the following:

- there is a reasonable expectation that the participant will continue to live in the home;
- written permission is secured from the property owner for the adaptation, including that there is no expectation that waiver funds will be used to return the home to its original state;
- the landlord will not increase the rent because of the adaptation.

Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service. This service may not be provided to participants receiving Residential Habilitation or residing in Assisted Living Residences, Domiciliary Care Homes or other provider owned and operated settings.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment Provider
Individual	Contractor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Adaptations

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

Drug and Device Registration with the PA Dept of Health as required by the Controlled Substance, Drug, Device and Cosmetic Act and 28 PA Code Chapter 25.

Other Standard (specify):

Providers shall be authorized by the manufacturer to install, repair and maintain modifications/adaptations. Home modifications must meet life/safety and building codes and be inspected by the appropriate authority when required.

In addition, providers shall:

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
- Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
- Have Commercial General Liability insurance
- Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs, if applicable.
- All Home Adaptations installed shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply
- Organizations must have capacity to provide 24-hour coverage by trained professionals, 365 days/year

Individuals working for or contracted with agencies must meet the following standards:

- Be at least 18 years of age
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
- Have a child abuse clearance as required in Appendix C-2-b
- 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Adaptations

Provider Category:

Individual

Provider Type:

Contractor

Provider Qualifications

License (specify):

Licensed in accordance with the requirements of the local jurisdiction, as required by trade.

Certificate (*specify*):

N/A

Other Standard (*specify*):

All services shall be provided in accordance with applicable State or local building codes. Providers shall possess a current license to do business issued in accordance with the laws of the local jurisdiction and shall demonstrate knowledge in meeting applicable standards of installation, repair and maintenance and where applicable shall also be authorized by the manufacturer to install, repair and maintain such modifications/adaptations. Home modifications must meet life/safety and building codes and be inspected by the appropriate authority when required. Contractors must be conflict free and cannot have a vested interest in the property that is being modified.

In addition, providers shall:

- Have or demonstrate knowledge about design, construction, and costs of accessibility modifications.
- Have experience in Americans with Disabilities Act compliance standards and design.
- Comply with 55 PA Code 1101 and have a waiver provider agreement.
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications.
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service.
- Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies.
- Have Commercial General Liability insurance.
- Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs, if applicable, and demonstrate the ability to work successfully with people with disabilities and the elderly, and their families.
- All Home Adaptations installed shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply.
- Providers with a waiver service location in states contiguous to Pennsylvania must have a comparable license.
- Providers must be in compliance with and knowledgeable of the Pennsylvania Home Improvement Consumer Protection Act and other applicable standards.

Individuals working for or contracted with agencies must meet the following standards:

- Be at least 18 years of age
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs, if applicable.
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
- Have a child abuse clearance as required in Appendix C-2-b
- 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:

06 Home Delivered Meals

Sub-Category 1:

06010 home delivered meals

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

The Home Delivered Meals service provides meals that meet at least one-third of the Dietary Reference Intakes to people in their private homes. Home Delivered Meals provides meals to waiver participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. Home Delivered Meals must be specified in the service plan, as necessary, to promote independence and to ensure the health, welfare and safety of the participant.

Participants may receive more than one meal per day, but they cannot receive meals that constitute a “full nutritional regimen” (three meals per day).

All meals must be consistent with a prescribed menu approved by a dietician and, in accordance with the menu:

- May consist of hot, cold, frozen, dried, canned, fresh or supplemental foods
- Can either be a hot, cold, frozen or shelf-stable meal

Meals may be delivered as singles or multiples, as long as the number of planned daily meals does not exceed two meals per day and the participant has appropriate storage and support to ensure that meals last as intended.

All menus must be approved and signed by an approved dietitian.

The frequency and duration of Home Delivered Meals are based upon the participant’s needs, as identified and documented in the participant’s service plan.

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

Home Delivered Meals are provided only during those times when neither the participant nor anyone else in the household is able or available to provide them, and where no other relative, caregiver, community/volunteer agency or third-party payer is able to provide, or be responsible for, their provision.

Meals provided as part of this service shall not constitute a full nutritional regimen (three meals per day).

Transportation for the delivery of meals is included in the service cost and will not be reimbursed separately.

This service may not be included on the same service plan as Residential Habilitation.

Participants eligible for non-waiver nutritional services, including the Older Americans Act, will access those services first.

This service should supplement and not supplant resources to which the participant may be entitled including the Supplemental Nutritional Assistance Program (SNAP).

This service does not include nutritional assessment, education or counseling, but may be used in conjunction with a nutritional service offered through the waiver when needed for the participant.

Area Agencies on Aging and service providers may not solicit donations for Home Delivered Meals from waiver participants.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Delivered Meals Vendors

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meals Vendors

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

- Safe food handling, preparation and transportation standards conform with Title 7 PA Code Chapter 46, Food Code

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Service Specification**

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

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Job Finding is an individualized service that assists participants to obtain competitive, integrated employment. Competitive integrated employment is full or part-time work at minimum wage or higher, with wages and benefits similar to those without disabilities performing the same work, and fully integrated with co-workers without disabilities. Job Finding services are necessary, as specified in the service plan, to support the participant to live and work successfully in home and community-based settings, enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

Job Finding identifies and/or develops potential jobs and assists the participant in securing a job that fits the participant's skills and preferences and employer's needs. If the participant has received a Career Assessment, the results of that assessment must be included within the participant's service plan and considered by the Job Finding service.

Job Finding may include customized job development. Customized job development is based on individualizing the employment relationship between employees and employers in a way that matches the needs of the employer with the assessed strengths, skills, needs, and interests of the participant, either through task reassignment, job carving, or job sharing.

Job Finding, which may include prospective employer relationship building, is time-limited. Job Finding requires authorization up to 90 days, with re authorization every 90 days, for up to 1 year. At each 90-day interval, the service plan team will meet to clarify employment goals and expectations and review the job finding strategy. 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.

The service also includes transportation as an integral component of the service, such as to a job interview, during the delivery of Job Finding.

If the participant receives Behavior Therapy services, this service includes implementation of the behavior support plan and, if necessary, the crisis support plan. The service includes collecting and recording the data necessary to support the review of the service plan, the behavior support plan and the crisis support plan, as appropriate.

Job Finding is provided on a 1:1 basis.

Complete payment for Job Finding will require achievement of milestones as identified by the Department.

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

Job Finding services may not be rendered under the waiver to a participant under a program funded by either the Rehabilitation Act of 1973 as amended or any other small business development resource available to the participant. This means that job finding may only be provided when documentation has been obtained that one of the following has occurred:

1. OVR has closed a case for the participant or has stopped providing services to the participant;
2. The participant was determined ineligible for OVR services; or
3. It has been determined that OVR services are not available. If OVR has not made an eligibility determination within 120 days of the referral being sent, then OVR services are considered to not be available to the participant.

In the event that OVR closes the order of selection, the following process will be followed until the closure is lifted:

1. A participant who has been referred to OVR but does not have an approved Individualized Plan for Employment (IPE) may receive Job Finding.
2. A participant who has not been referred to OVR may receive Job Finding without a referral to OVR.

Documentation in accordance with Department requirements must be maintained in the file by the Service Coordinator and updated with each reauthorization to satisfy the State assurance that the service is not otherwise available to the participant under other federal programs.

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

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. The Job Finding Service may be provided in conjunction with other employment related services such as Career Assessment, Employment Skills Training and Job Coaching.

Job Finding does not include activities covered through Job Coaching once employment is obtained.

Job Finding does not include skills training to qualify for a job.

Federal Financial Participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in Job Finding services
- Payments that are passed through to users of the Job Finding 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	Job Finding Provider
Agency	Job Finding Agency

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Job Finding**

Provider Category:

Individual

Provider Type:

Job Finding Provider

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used as a component of this service

See "Other Standard"

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
- Have Commercial General Liability insurance in accordance with Department policies
- Be at least 18 years of age
- Meet the qualifications for a Vocational Rehabilitation Counselor, as defined by the PA Department of Labor and Industry, Office of Vocational Rehabilitation; or
- Have a bachelor's degree in rehabilitation, psychology, sociology, business, marketing or related field and 1 year of documented related experience; or
- Have an associate's degree in rehabilitation, psychology, sociology, business, marketing or related field and 2 years of documented related experience; or
- Have a high school diploma or GED and at least 3 years of documented related experience
- Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
- One of the following within 18 months of employment:
 - Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE)
 - Been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.
- Individuals who meet the qualifications for Vocational Rehabilitation Counselors are exempt from this provision.
- Individuals without certification must be supervised by an individual holding the above certification until certification is achieved. Certification must be achieved within 18 months of employment.
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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: Job Finding****Provider Category:**

Agency

Provider Type:

Job Finding Agency

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used as a component of this service

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
 - Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
 - Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
 - Have Commercial General Liability insurance
 - Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age
 - Meet the qualifications for a Vocational Rehabilitation Counselor, as defined by the PA Department of Labor and Industry, Office of Vocational Rehabilitation; or
 - Have a bachelor's degree in rehabilitation, psychology, sociology, business, marketing or related field and 1 year of documented related experience; or
 - Have an associate's degree in rehabilitation, psychology, sociology, business, marketing or related field and 2 years of documented related experience; or
 - Have a high school diploma or GED and at least 3 years of documented related experience
 - Comply with all Department standards regarding 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 valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service
- Individuals working directly with the participant to provide job finding services shall hold one of the following within 18 months of employment:
- Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE)
 - Been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.
 - Individuals who meet the qualifications for Vocational Rehabilitation Counselors are exempt from this provision.
 - Individuals without certification must be supervised by an individual holding the above certification until certification is achieved. Certification must be achieved within 18 months of employment.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:

15 Non-Medical Transportation

Sub-Category 1:

15010 non-medical transportation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Non-Medical Transportation services are offered in order to enable participants to gain access to long-term services and supports as specified in the PCSP. This service is offered in addition to medical transportation services required under 42 CFR 440.170 (a) (if applicable), and shall not replace them. Non-Medical Transportation services include mileage reimbursement for drivers and others to transport a participant and/or the purchase of tickets or tokens to secure transportation for a participant. Non-Medical Transportation must be billed per one-way trip or billed per item, for example a monthly bus pass. Transportation services must be tied to a specific objective identified on the participant's service plan.

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

Medical Assistance Transportation Program (MATP) services will be used for obtaining State Plan services. The participant's service plan must document the need for those Non-medical Transportation services that are not covered under the Medical Assistance Transportation Program.

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

Non-Medical Transportation does not cover reimbursement to the participant or another individual when driving the participant's vehicle. Non-Medical Transportation does not pay for vehicle purchases, rentals, modifications or repairs.

Non-Medical Transportation cannot be provided at the same time as Adult Daily Living services with transportation or Employment Skills Development, Career Assessment or Job Finding. An individual cannot provide both Personal Assistance Services and Non-Medical Transportation simultaneously.

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

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

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

Participant-directed as specified in Appendix E

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 Driver
Agency	Licensed Transportation Agency, Public Transit Authority

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Individual Driver

Provider Qualifications

License (*specify*):

Valid Pennsylvania drivers license appropriate to the vehicle

Certificate (*specify*):

Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used to provide the Transportation service.

Other Standard (*specify*):

Drivers must meet the following:

- 18 years of age;
- Must have appropriate insurance coverage (\$100,000/\$300,000 bodily injury);
- Have automobile insurance for all automobiles used to provide the Transportation service;
- Vehicles must be registered with the PA Department of Transportation;
- Receive a physical examination (including a vision test) at the time of hire and at least every 2 years; and
- Be willing to provide door-to-door services.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Licensed Transportation Agency, Public Transit Authority

Provider Qualifications

License (*specify*):

Licensed by the P.U.C and/or be a Public Transit Authority, a Community Transportation Provider or Community Transportation Subcontractor

Certificate (*specify*):

N/A

Other Standard (*specify*):

Agencies must:

- Meet PA Vehicle Code (Title 75);
- Have Commercial General Liability insurance;
- Have automobile insurance for all automobiles owned, leased and/or hired and used to provide the Transportation service;
- Have Workers' Compensation insurance in accordance with State statute;
- Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, which includes, but is not limited to, communication, mobility and behavioral needs; and
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52.

Drivers employed by licensed transportation agencies and public transit authorities must meet the following:

- be at least 18 years of age;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15;
- Have child abuse clearance as required in Appendix C-2-b;
- Agree to carry out the Transportation outcomes included in the participant's service plan; and
- Have a valid driver's license if the operation of a vehicle is necessary to provide Transportation services.

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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:

Nutritional Consultation

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11040 nutrition consultation

Category 2:

Sub-Category 2:

Category 3:**Sub-Category 3:**☐**Service Definition (Scope):****Category 4:****Sub-Category 4:**☐

Nutritional Consultation services are services that assist individuals to improve functioning and independence and are necessary to improve the individual's inclusion in their community. Services are provided by professionals and/or paraprofessionals in nutritional counseling. The service may include initial assessment and reassessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan, and monitoring of the participant, caregiver and any providers in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

Nutritional Consultation assists the participant and/or their paid and unpaid caregivers in developing a diet and planning meals that meet the participant's nutritional needs, while avoiding any problem foods that have been identified by a physician. Services include counseling performed by a Registered Dietitian or a Certified Nutrition Specialist. The purpose of Nutritional Consultation services is to improve the ability of participants, paid and/or unpaid caregivers and providers to carry out nutritional interventions. Nutritional Counseling services are limited to 90-minutes (6 units) of nutritional consultations per month. Home Health Agencies that employ licensed and registered dietitians may provide nutritional counseling.

This service requires a recommendation by a physician.

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

This service is not covered in the State Plan.

Nutritional Consultation Services may only be funded through the waiver when the service is not covered by another responsible third party, such as Medicare or private insurance. This may be because the Medicare or insurance limitations have been reached, or the service is not covered under Medicare or private insurance.

The Service Coordinator is responsible for verifying and documenting in the participant's file that private insurance limitations have been exhausted or that the private insurance provider does not have the expertise or experience specific to the disability prior to funding services through the waiver. Documentation must be maintained in the individual's file by the Service Coordinator. This documentation must be updated annually.

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Dietitian or Certified Nutrition Specialist
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritional Consultation

Provider Category:

Individual

Provider Type:

Registered Dietitian or Certified Nutrition Specialist

Provider Qualifications

License (*specify*):

Licensed by the PA State Board of Dietitian-Nutritionists, per 49 PA Code Chapter 21, subchapter G

Certificate (*specify*):

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, including regulations, policies and procedures relating to provider qualifications;
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service;
- Be a resident of Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance in accordance with Department policies;
- Be at least 18 years of age;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
- Have a child abuse clearance as required in Appendix C-2-b; and
- Title 49 PA Code Ch. 21 Subchapter G relates to the general provisions, licensure requirements and the responsibilities of the licensed dietician-nutritionist issued under sections 2.1(k) and 11(c) of the Professional Nursing Law (63 P. S. § 212(k) and 221(c)).

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritional Consultation

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License** (*specify*):

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

Certificate (*specify*):

Certification as required by 42CFR Part 484

Other Standard (*specify*):

Agency:

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

Individuals working for or contracted with agencies must meet the following standards:

- Be 18 years of age or older;
- Possess basic math, reading and writing skills;
- Complete training or demonstrate competency by passing a competency test as outlined in Section 601.6 under Title 28, Part IV Subpart G of the Health Care Facilities Act;
- Be a Registered Dietician or Certified Nutrition Specialist licensed by the PA State Board of Dietitian-Nutritionists, per 49 PA Code Chapter 21, subchapter G;
- 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 required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

This service is only available through the Services My Way (budget authority) participant-directed 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, trained, managed, and when necessary, fired by the participant.

Participant-Directed Community Supports 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 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;
- 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.

This service may include assistance with the following activities when incidental to Participant-Directed Community Supports and necessary to complete activities of daily living:

- Accompanying 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, and to enable the participant to work and to otherwise engage in activities in the community.
- Homemaker tasks that are incidental to the delivery of Participant-Directed Community Supports 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.

The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021 in accordance with the Good Faith Exemption granted by the Centers for Medicare and Medicaid Services and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

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

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

Participant-Directed Community Supports are provided only for the participant and not for other household members, when neither the participant nor anyone else in the household, relative or informal caregiver is available, willing and able to perform such activities for the participant and where no community/volunteer agency or third-party payer is capable or responsible for their provision.

Individual Support Workers who live in the same residence as the participant cannot be compensated for carrying out household chores such as shopping, laundry and cleaning unless the activity is being completed solely to benefit the participant.

Participant-Directed Community Supports may not be provided at the same time as Home Health Aide Services, Respite, Personal Assistance Services, Residential Habilitation, Adult Daily Living and Structured Day Habilitation.

An individual cannot provide both Participant-Directed Community Supports and Non-Medical Transportation simultaneously.

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 Support Services Worker

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Participant-Directed Community Supports

Provider Category:

Individual

Provider Type:

Individual Support Services Worker

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Have a 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 required in Appendix C-2-b; 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 the Fiscal/Employer Agent

Frequency of Verification:

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Participant-Directed Goods and Services

HCBS Taxonomy:**Category 1:**

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

☐

Category 3:

Sub-Category 3:

☐

Service Definition (Scope):

Category 4:

Sub-Category 4:

☐

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 one or more of the following requirements:

- Decrease the need for other Medicaid services;
- Promote or maintain inclusion in the community;
- Promote the independence of the participant, or decrease dependency on formal support services;
- Increase the individual's health and safety in the home environment,
- Develop or maintain personal, social, physical or work-related skills; or
- Fulfill a medical, social or functional need as identified in the participant's person-centered service plan; AND,
- The participant does not have the funds to purchase the item or service or the item or service is not available through another source.

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

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

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

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

The Service Coordinator or CHC-MCO is responsible to ensure that provision of Participant-Directed Good and Services does not overlap with other service provision.

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
Agency	CHC Program's F/EA Vendor
Individual	Individual Vendors, Businesses and Independent Contractors

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:

CHC Program's F/EA Vendor

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance;
- 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 required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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: Participant-Directed Goods and Services

Provider Category:

Individual

Provider Type:

Individual Vendors, Businesses and Independent Contractors

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- 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; and
- Have a child abuse clearance as required in Appendix C-2-b.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The participant and the F/EA.

Frequency of Verification:

At time of service provision or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14010 personal emergency response system (PERS)

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

A Personal Emergency Response System (PERS) is an electronic device that transmits a signal to a central monitoring center to summon assistance in the event of an emergency. The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring center with backup systems which is staffed at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each participant.

A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a participant to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a participant who is unable to request help or to activate a system independently. A portable locator system can be obtained as PERS only if the participant is unable to access assistance in an emergency situation due to the participant's age or disability. The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the participant.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each participant as applicable.

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; or
- Would otherwise require extensive in-person routine monitoring and assistance.

Installation, including equipment testing, and monthly monitoring fees, including monthly equipment rental, are covered in this service.

A unit of service is a one-time installation fee or a monthly monitoring fee. Maintenance and repair of PERS rental equipment is the responsibility of the provider. In addition, provider staff are responsible for training participants regarding the use of the system.

PERS equipment shall include a variety of remote or other specialty activation devices from which the individual can choose in accordance with their specific needs. All PERS equipment shall have an internal battery that provides at least twenty-four hours of power without recharging and sends notification to the emergency response center when the battery's level is low. Equipment includes, but is not limited to:

- Wearable waterproof activation devices; and
- Devices that offer:
 - Voice-to-voice communication capability,
 - Visual indication of an alarm that may be appropriate if the consumer is hearing impaired, or
 - Audible indication of an alarm that may be appropriate if the consumer is visually impaired.

PERS does not include the following:

- Equipment such as a boundary alarm, a medication dispenser, a medication reminder, or any other equipment or home medical equipment or supplies, regardless of whether such equipment is connected to the PERS equipment.
- Stand-alone smoke or carbon monoxide detectors.
- Remote Telecare monitoring services, i.e., Health Status Measuring and Monitoring and Activity and Sensor Monitoring.
- Monthly telephone charges associated with the participant's phone service.

When previously approved equipment has been damaged as a result of misuse, abuse or negligence, the CHC-MCO will make the determination around the cost-effectiveness of repairing and/or replacing damaged equipment or providing the participant with additional supports.

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.

The cost of training participants is included in the charges for installation or the monthly monitoring fee, depending upon how the CHC-MCO and/or provider structures their fee schedule. The maximum units per calendar year shall be one initial installation fee and 12 months of monthly monitoring service. The provider may not charge any additional costs over and above the installation and monthly monitoring fees.

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

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment and Supply Company
Agency	Vendors of Personal Emergency Response Systems
Agency	Home Health Agency

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.
- 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 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 required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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 required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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:

Home Health Agency

Provider Qualifications

License (specify):

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

Certificate (specify):

Certification as required by 42CFR Part 484

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance; and
- Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies.
- 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 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 required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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:

Pest Eradication

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:**Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Pest Eradication services are services that suppress or eradicate pest infestation that, if not treated, would prevent the participant from remaining in the community due to a risk of health and safety. Pest Eradication Services are intended to aid in maintaining an environment free of insects, rodents and other potential disease carriers to enhance safety, sanitation and cleanliness of the participant's residence. This service can be made available on an ongoing basis to prevent reinfestation only when reinfestation is likely to occur and the service coordinator determines the reinfestation would negatively impact the participant's health and safety. The service coordinator must consult the Pest Control Provider to determine the likelihood of reinfestation. The justification for ongoing services must be documented in the PCSP. Documentation must include the amount, duration and scope of services as determined by the Service Coordinator. Pest Eradication services are only permissible for individuals residing in their own home. The service cannot be made available as a preference of the participant to remove something on a property that has no impact on the participant living there.

Service coordinators are responsible for ensuring that no other resource is available to have this service done. Service Coordinators must ensure that local health departments or other available resources could not provide this service. Service Coordinators must also determine if landlords are required to provide this service to make the rental property habitable. This can be done by reviewing the lease to determine the landlord's responsibility. Service Coordinators need to be familiar with local housing requirements, local housing authority requirements, or local ordinances on rental properties related to rental property requirements on pest control. Service Coordinators will contact landlords to convey the importance of maintaining and treating adjoining properties once the participant's property is treated for pests. This is to ensure that pests do not return to the participant's residence.

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

Pest Eradication services may not be used solely as a preventative measure; there must be documentation of a need for the service either through Service Coordinator direct observation or individual report that a pest is causing or is expected to cause harm that would prevent a participant from safely remaining in the community. Service Coordinators must provide the affected participant with educational materials or locate appropriate training on pests to aid in keeping a treated residence pest free in the future. When pest eradication is needed, Service Coordinators must also review the affected participant's person-centered service plan to assess infestation risks and develop a risk mitigation plan.

Service Coordinators must have reasonable assurance that the participant plans to live in the property for the foreseeable future if the pest control service is provided. This needs to be documented in the PCSP.

The Service Coordinators will also determine from the participant if they have any health conditions that need to be considered by the pest control provider. Such health conditions would need to be considered in determining the method of pest control used so as to not adversely affect the health of the participant.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by (check each that applies):****Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Pest Control Company

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Pest Eradication

Provider Category:

Agency

Provider Type:

Pest Control Company

Provider Qualifications

License (*specify*):

Licensed pest application business by the PA Department of Agriculture under 7 Pa Code Chapter 128

Certificate (*specify*):

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;
- Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance;

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 required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

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

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

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

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

This service is not covered in the State Plan. Participants can only receive TeleCare services when they meet eligibility criteria specified in the state's published TeleCare Services policy guidance, and the services are not covered under Medicare or other third party resources.

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

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

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

TeleCare services cannot be provided at the same time as Residential Habilitation Services.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment and Supply Company
Agency	Home Health Agency
Agency	Hospital
Agency	Pharmacy

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: TeleCare

Provider Category:

Agency

Provider Type:

Durable Medical Equipment and Supply Company

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
 - Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
 - Have Commercial General Liability insurance;
 - Meet provider requirements as specified in the TeleCare Services Directive;
 - Evaluation of participant data is completed by a licensed registered nurse or licensed practical nurse; and
 - Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies.
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age;
 - Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
 - Have a child abuse clearance as required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: TeleCare****Provider Category:**

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

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

Certificate (specify):

Certification as required by 42 CFR Part 484

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
 - Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
 - Have Commercial General Liability insurance;
 - Meet provider requirements as specified in the TeleCare Services Directive;
 - Evaluation of participant data is completed by a licensed registered nurse or licensed practical nurse; and
 - Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies.
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age;
 - Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
 - Have a child abuse clearance as required in Appendix C-2-b;
 - Be supervised by a registered nurse, as appropriate; and
 - Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: TeleCare****Provider Category:**

Agency

Provider Type:

Hospital

Provider Qualifications**License (specify):**

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

Certificate (specify):

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

Other Standard (specify):

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
 - Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
 - Have Commercial General Liability insurance;
 - Meet provider requirements as specified in the TeleCare Services Directive;
 - Evaluation of participant data is completed by a licensed registered nurse or licensed practical nurse; and
 - Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies.
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age;
 - Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
 - Have a child abuse clearance as required in Appendix C-2-b; 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or more frequently when deemed necessary by the Department.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: TeleCare****Provider Category:**

Agency

Provider Type:

Pharmacy

Provider Qualifications**License (specify):**

Permit to conduct a pharmacy, under 49 PA Code, Part I, Subpart A. Chapter 27

Certificate (specify):**Other Standard (specify):**

- Comply with 55 PA Code 1101 and have a signed Medicaid waiver provider agreement;
 - Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
 - Have Commercial General Liability insurance;
 - Meet provider requirements as specified in the TeleCare Services Directive;
 - Evaluation of participant data is completed by a licensed registered nurse or licensed practical nurse; and
 - Meet State regulations under 55 PA Code 1123 regarding participation for medical supplies.
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age;
 - Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code, Chapter 52;
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15; and
 - Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OLTL or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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:

Vehicle Modifications

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

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

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Vehicle Modifications are modifications or alterations to an automobile or van that is the participant's means of transportation in order to accommodate the special needs of the participant. Vehicle Modifications are modifications needed by the participant, as specified in the service plan and determined necessary in accordance with the participant's assessment, to ensure the health, welfare and safety of the participant, and enable the participant to function in the home and community with greater independence and integrate more fully into the community. The vehicle that is modified may be owned by the participant, a family member who provides primary support, or a non-relative who provides primary support to the participant and is not a paid provider agency of services.

The following are specifically excluded:

- Modifications or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the participant, and
- Regularly scheduled upkeep and maintenance of a vehicle, including warranties that cover the entire vehicle, except upkeep and maintenance of the modifications.

The waiver cannot be used to purchase chassis for participants, their families or legal guardians; however, this service can be used to fund the portion of a new or used vehicle purchase that relates to the cost of accessibility adaptations. In order to fund these types of adaptations, a clear breakdown of purchase price versus adaptation is required to be provided by a vehicle modifications contractor.

Vehicle Modifications funded through the waiver are limited to the following:

- Vehicular lifts;
- Portable ramps when the sole purpose of the ramp is for the participant to access the vehicle;
- Interior alterations to seats, head and leg rests, and belts;
- Customized devices necessary for the participant to be transported safely in the community, including tie-downs and wheelchair docking systems;
- Driver control devices, including hand controls and pedal adjusters;
- Modifications needed to accommodate a participant's special sensitivity to sound, light or other environmental conditions;
- Raising the roof or lowering the floor to accommodate wheelchairs; and
- The vehicle cannot exceed 5 calendar years old and must have less than 50,000 miles for vehicle modification requests over \$5,000.

All Vehicle Modifications shall meet applicable standards of manufacture, design and installation.

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

A vehicle is required to have passed all applicable State standards.

This service does not include, but requires, an independent evaluation.

Vehicle Modifications must be obtained in the least expensive, most cost-effective manner.

Participants receiving Vehicle Modifications cannot be authorized for Residential Habilitation services during the same time period.

Depending on the type of modification, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by a licensed occupational therapist, physical therapist or Mobility Specialist meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through another waiver service or the State Plan, as appropriate.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vehicle Modifications Contractor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Vehicle Modifications Contractor

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

Quality Assurance Program (QAP) Accreditation by the National Mobility Equipment Dealers Association (NMEDA).

Other Standard (*specify*):

- Comply with 55 PA Code 1101 and have a waiver provider agreement
 - Comply with Department standards, including regulations, policies and procedures relating to provider qualifications
 - Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania
 - Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies
 - Have Commercial General Liability insurance
 - Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant; for example, communication, mobility and behavioral needs
 - Adhere to all applicable local and State codes
- Individuals working for or contracted with agencies must meet the following standards:
- Be at least 18 years of age
 - Comply with all Department standards including regulations, policies and procedures related to provider qualifications
 - Complete Department required training, including training on the participant's service plan and the participant's unique needs, which may include, but is not limited to, communication, mobility, and behavioral needs
 - Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15
 - Have a child abuse clearance as required in Appendix C-2-b
 - 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 or its designee

Frequency of Verification:

At time of enrollment and revalidation or 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.*

As a primary care case management system service under a concurrent managed care authority. *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:

The CHC-MCO will provide service coordination as an administrative function. The Service Coordination function must be provided by an appropriately qualified Service Coordinator employed by or under contract with the CHC-MCO.

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.

Service Coordinators are responsible for assisting Participants in obtaining the services that they need. Service Coordinators lead the Person-Centered Service Planning process and oversee the implementation of Person-Centered Services Plans (PCSPs). CHC-MCOs must annually submit and obtain Department approval of their Service Coordination staffing, caseloads, the required frequency of in-person contact with Participants, and how Service Coordinators share and receive real-time information about Participants and Participant encounters.

Service Coordination includes activities to identify, coordinate and assist participants to gain access to needed Covered Services and non-Covered Services such as 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. Service Coordinators are responsible to: inform Participants about available LTSS, required needs assessments, the Participant-centered service 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, and ensuring the health, welfare and safety of the Participant on an on-going basis.

Service Coordinators must: collect information to inform the development of the PCSP, including, at a minimum, the Participant's preferences, strengths and goals; conduct the comprehensive needs assessment, at least annually or more frequently as needed in accordance with Department requirements; assist the Participant and his/her person-centered service planning team to identify and choose willing and qualified providers; coordinate efforts and prompt the Participant to complete activities necessary to maintain waiver eligibility; 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; and actively coordinate with other individuals and/or entities essential in the physical and/or behavioral care delivery for the Participant, including other care coordinators, to ensure seamless coordination between physical, behavioral and support services.

In the performance of the coordinating function, the Service Coordinator will:

- Coordinate efforts in accordance with Department requirements and prompt the participant to participate in the completion of a needs assessment as required by the State to identify appropriate levels of need and to serve as the foundation for the development of and updates to the service plan.
- Use a person-centered planning approach and a team process to develop the participant's service plan to meet the participant's needs in the least restrictive manner possible. At a minimum, the approach shall:
 - Include people chosen by the participant for service plan meetings, review assessments, including discussion of needs, to gain understanding of the participant's preferences, suggestions for services and other activities key to ensure a participant-centered service plan.

*** Continued in Main Module B. Optional ***

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 direct care workers and must be conducted in accordance with 55 PA Code, Sections 52.19 and 52.20. Direct care 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 which access the Pennsylvania Crime Information Center (PCIC) and the National Crime Information Center (NCIC) for this information. The 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.

Under participant-direction, the CHC-MCOs' Fiscal Employer/Agent (F/EA) vendor is responsible for securing criminal history background checks for prospective direct care workers prior to hiring workers. 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 direct care worker with a criminal record and their acceptance of responsibility for their decision.

The CHC-MCOs, as part of their oversight of the F/EA contract, will ensure that criminal background checks will be completed timely. Staff will check to determine that criminal background checks are completed timely and that participants are notified of results. Corrective action will be implemented if it is found that the F/EA is not meeting established contract standards.

The CHC-MCO will review provider personnel records as part of their regular monitoring to ensure that criminal history checks are conducted and documented as required. In addition to regularly scheduled monitoring, OLTL may review records as necessary during incident report investigations or other circumstances as warranted.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Clearances are required for all direct care workers and service providers, including Service Coordinators and contractors, providing services in homes where children reside. A child is defined as an individual under 18 years of age.

The following three certifications must be obtained prior to providing services in homes where children reside:

- Report of criminal history from the Pennsylvania State Police (PSP);
- Fingerprint-based federal criminal history submitted through the Pennsylvania State Police or its authorized agent (FBI); and
- Child Abuse History Certification from the Department of Human Services (Child Abuse).

The option to provisionally hire a person for employment described in 55 Pa. Code Ch. 52.20 does not apply to the clearances required prior to providing services in homes where children reside.

Requests for criminal history reports can be processed through the Pennsylvania State Police web-based computer application called "Pennsylvania Access To Criminal History" (PATCH), at <https://epatch.state.pa.us>, or by submitting the "Request For Criminal Record Check" form SP4-164 (updated 12/2017) to the following address: Pennsylvania State Police, Central Repository – 164, 1800 Elmerton Avenue, Harrisburg, PA 17110-9758, (888) 783-7972.

The Department of Human Services utilizes IDEMIA, also referred to as Identigo and MorphoTrust, to process fingerprint-based FBI record checks. The fingerprint-based background check is a multiple step process. The IDEMIA website <https://www.identigo.com> allows individuals to apply online, as well as provide detailed information regarding the application process.

Child Abuse History Certifications are obtained online at <http://www.compass.state.pa.us/CWIS>, or through the DHS ChildLine and Abuse Registry, P.O. Box 8170, Harrisburg, Pennsylvania 17105-8170, (717) 783-6211 or toll free at (877) 371-5422.

For those workers required to have clearances (see above), written results are required prior to the employee/provider initiating services in the participant's home. Direct care workers who are employed by waiver participants who have children residing in their homes must have child abuse clearances completed prior to hire so that participants can make an informed decision on whether to employ a worker who has been named as a perpetrator of founded or indicated child abuse.

Beginning July 1, 2015, certifications must be obtained every 60 months regardless of service model. Any employee with current certification issued prior to July 1, 2015, must renew their certifications within 60 months from the date of their oldest certification or if their current certification is older than 60 months.

If an employee is arrested for or convicted of an offense that would constitute grounds for denying employment or participation in a program, activity or service, or is named as a perpetrator in a founded or indicated report, the employee must provide the administrator or their designee with written notice not later than 72 hours after the arrest, conviction or notification that the person has been listed as a perpetrator in the statewide database. An employee who willfully fails to disclose information as required above commits a misdemeanor of the third degree and shall be subject to discipline up to and including termination or denial of employment.

The employer, administrator, supervisor or other person responsible for employment decisions or acceptance of the individual to serve in any capacity requiring certifications, must have a system in place to document that the clearances were conducted and shall maintain copies of the required information.

The CHC-MCOs' F/EA vendor is responsible for securing clearances for prospective direct care workers. In addition, the F/EA must have a system in place to document that the clearances were conducted. The CHC-MCOs, as part of their oversight of the F/EA contract, will ensure that child abuse clearances will be completed timely. Staff will check to determine that child abuse clearances are completed timely. Corrective action will be implemented if it is found that the F/EA is not meeting established contract standards.

The CHC-MCO will review provider personnel records as part of their regular monitoring to ensure that child abuse clearances are conducted and documented as required. 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)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Personal Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Home Delivered Meals	
Personal Emergency Response System (PERS)	
Counseling Services	
Specialized Medical Equipment and Supplies	
Career Assessment	
Participant-Directed Goods and Services	
Speech and Language Therapy Services	
Community Integration	
Benefits Counseling	
Nursing Services	
Community Transition Services	
Nutritional Consultation	
Assistive Technology	
Home Health Aide Services	
Participant-Directed Community Supports	
Occupational Therapy Services	
Job Finding	
Vehicle Modifications	
TeleCare	
Behavior Therapy	
Job Coaching	
Physical Therapy Services	
Cognitive Rehabilitation Therapy Services	

Waiver Service	Provided in Facility
Non-Medical Transportation	
Home Adaptations	
Personal Assistance Services	
Pest Eradication	
Residential Habilitation	
Structured Day Habilitation Services	
Employment Skills Development	
Respite	
Adult Daily Living	

Facility Capacity Limit:

8

Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications**Facility Type:**

Assisted Living Residence

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Home Delivered Meals	
Personal Emergency Response System (PERS)	
Counseling Services	
Specialized Medical Equipment and Supplies	
Career Assessment	
Participant-Directed Goods and Services	
Speech and Language Therapy Services	
Community Integration	
Benefits Counseling	
Nursing Services	
Community Transition Services	
Nutritional Consultation	
Assistive Technology	
Home Health Aide Services	
Participant-Directed Community Supports	
Occupational Therapy Services	
Job Finding	
Vehicle Modifications	
TeleCare	
Behavior Therapy	
Job Coaching	
Physical Therapy Services	
Cognitive Rehabilitation Therapy Services	
Non-Medical Transportation	
Home Adaptations	
Personal Assistance Services	
Pest Eradication	
Residential Habilitation	
Structured Day Habilitation Services	
Employment Skills Development	

Waiver Service	Provided in Facility
Respite	
Adult Daily Living	

Facility Capacity Limit:

N/A

Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Domiciliary Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Home Delivered Meals	

Waiver Service	Provided in Facility
Personal Emergency Response System (PERS)	
Counseling Services	
Specialized Medical Equipment and Supplies	
Career Assessment	
Participant-Directed Goods and Services	
Speech and Language Therapy Services	
Community Integration	
Benefits Counseling	
Nursing Services	
Community Transition Services	
Nutritional Consultation	
Assistive Technology	
Home Health Aide Services	
Participant-Directed Community Supports	
Occupational Therapy Services	
Job Finding	
Vehicle Modifications	
TeleCare	
Behavior Therapy	
Job Coaching	
Physical Therapy Services	
Cognitive Rehabilitation Therapy Services	
Non-Medical Transportation	
Home Adaptations	
Personal Assistance Services	
Pest Eradication	
Residential Habilitation	
Structured Day Habilitation Services	
Employment Skills Development	
Respite	
Adult Daily Living	

Facility Capacity Limit:

3

Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

6 Pa. Code Chapter 21, Domiciliary Care Services for Adults, does not specifically address staff supervision. As defined in the regulations, a Domiciliary Care Home is “a premises certified by the local Area Agency on Aging (AAA) for the purpose of providing a supervised living arrangement in a homelike setting for a period exceeding 24 consecutive hours.” Individuals living in Domiciliary Care Homes are usually living in an individual’s home; these settings do not lend themselves to traditional staff supervision. Rather, Domiciliary Care providers are overseen by the local Area Agencies on Aging (AAA). The local AAAs are responsible for the initial and ongoing certification of each domiciliary care home and training of domiciliary care home providers. The participant’s Service Coordinator is responsible for developing the participant’s Person-Centered Service Plan (PCSP) and monitoring the provision of services in accordance with the approved PCSP.

As noted in Appendix G, restraints and other forms of restrictive interventions are prohibited. Please see Appendix G for additional information.

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.*

--

Self-directed

Agency-operated

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 Respite, Personal Assistance Services and Participant-Directed Community Supports; however, the following exclusions apply:

- The CHC Waiver will not pay for services furnished by the participant's spouse.
- The CHC Waiver will not pay for services furnished by a legal guardian.
- The CHC Waiver will not pay for services furnished by a Representative Payee.
- The CHC Waiver will not pay for services furnished by a Power of Attorney (POA).

Aside from the exceptions noted above, there are no restrictions on the types of family members who may provide Respite, Personal Assistance Services and Participant-Directed Community Supports.

Family members who provide Respite, Personal Assistance Services and Participant-Directed Community Supports must meet the same provider qualification standards as direct care workers who provide Respite, Personal Assistance Services and Participant-Directed Community Supports to non-relatives. Individual service plans for individuals who receive more than 40 hours per week of Respite, Personal Assistance Services and Participant-Directed Community Supports services from one individual (family member or non-family member) will be reviewed and approved by the CHC-MCO. The CHC-MCOs will monitor the provision of services in accordance with OLTL established protocols.

Like all providers, family members who provide Respite, Personal Assistance Services and Participant-Directed Community Supports must submit signed time sheets of service delivery hours to the F/EA. The F/EA will review authorized billable units through the CHC-MCO's billing system. Reimbursement for services will be made through the CHC-MCOs.

The F/EA shall receive and maintain electronic authorization data from the MCO for each self-directed service appearing on the service plan and authorized by the MCO. When a common-law employer (CLE) submits a timesheet for their employee, the F/EA will ensure that units are available based on the available authorization(s) and that the DCW is paid at the rate established by their CLE.

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:

As a condition of participation in the CHC waiver, potential providers must meet the requirements set forth in 55 PA 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. All willing and qualified providers have the opportunity to enroll as waiver providers with OLTL at any time; OLTL has continuous open enrollment of providers and does not limit the application for provider enrollment to a specific time frame.

Copies of the forms for provider enrollment are available upon request from the OLTL and are also available to potential providers online through the DHS website: <https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx>

OLTL will forward a list of all enrolled providers to the CHC-MCOs on a monthly basis. The CHC-MCO will choose the providers they will contract with as part of their provider network from this list of providers. CHC-MCOs are required to contract with a sufficient number of providers to demonstrate network adequacy.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

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

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

Performance Measure:

QP-1: Number and percent of newly enrolled providers who meet licensure and/or certification standards prior to service provision. Numerator: Number of newly enrolled providers who meet required licensure and/or certification standards prior to service provision. Denominator: Number of newly enrolled providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OLTL Provider enrollment database

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

collection/generation (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 = <div></div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div>Bi-Annually</div>	

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: <div></div>	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

QP-2: Number and Percent of enrolled licensed/certified waiver providers who continue to meet regulatory and applicable waiver standards. Numerator: Number of enrolled providers who meet licensure QP standards. Denominator: Number of enrolled providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OLTL Provider enrollment database

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

	Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">Bi-Annually</div>	
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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: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

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

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

Performance Measure:

QP-3: Number and percent of newly enrolled non-licensed or non-certified waiver providers who meet regulatory and applicable waiver standards. Numerator: Number of newly enrolled non-licensed or non-certified providers who meet regulatory and applicable waiver standards. Denominator: Number of new providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OLTL Provider enrollment database

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

QP-4: Number and percent of non-licensed or non-certified waiver providers who continue to meet regulatory and applicable waiver standards. Numerator: Number of non-licensed or non-certified waiver providers who continue to meet regulatory and applicable waiver standards. Denominator: Number of non licensed/non-certified providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OLTL Provider enrollment database

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

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

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

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

Performance Measure:

QP-5: Number and percent of new HCBS providers meeting provider training requirements. Numerator: Number of new HCBS providers who meet training requirements. Denominator: Total number of new HCBS providers in the CHC-

MCO network.**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligations and validated by OLTL

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 = <div></div>
Other Specify: <div>CHC-MCO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div>Bi-Annually</div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

QP-6: Number and % of HCBS providers who were not newly enrolled in the current calendar year (CY) who met the provider training requirements in the current CY.

Num: Total # of HCBS providers who were not newly enrolled in the current CY and met the provider training requirements in the current reporting quarter. Denom: Total # of HCBS providers who were not newly enrolled in the current CY.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligations and validated by OLTL

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify:	Annually	Stratified Describe Group:

CHC-MCO		
	Continuously and Ongoing	Other Specify:
	Other Specify: Bi-Annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
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.

OLTL staff monitors the CHC-MCOs utilizing Core Teams. Each Core Team is comprised of a Program Specialist Registered Nurses, Social Workers, and Fiscal Representatives, and serves as the liaison between OLTL and each CHC-MCO. The Core Teams will monitor the CHC-MCOs on a regular basis. CHC-MCOs will be required to submit quarterly provider network reports, as well as quarterly compliance reports that identify CHC-MCO provider reviews, actions, education and corrective action plans. The Core Teams will utilize a standardized monitoring tool, and monitors CHC-MCOs against the requirements outlined in the CHC-MCO Agreement. OLTL will also review to ensure the provider has the appropriate licensure as required by the waiver prior to enrolling the provider.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States 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.

Before a provider is enrolled as a qualified waiver provider, the provider must provide written documentation to the State Medicaid Agency (OLTL) that it meets all state licensing and certification requirements. Additionally, a provider is required to provide documentation that it meets all waiver provider qualifications that are not part of licensure or certification. 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 provides information on available resources the provider can access to improve or develop internal systems to meet the required provider qualifications. If a provider is unable to meet the required qualifications, the application to provide waiver services is denied. The provider may reapply with OLTL if verification is obtained.

Provider's credentials are revalidated every five years from the date of the previous validation.

Oversight of Pennsylvania's agreements with the managed care organizations will be performed by the Bureau of Coordinated and Integrated Services (BCIS). The agreements with the CHC-MCOs require the CHC-MCO's to submit monthly, quarterly and annual reports to BCIS on internal quality assurance/improvement activities such as consumer and provider surveys, performance measures, complaints and grievances and other issues or concerns that affect network access and service delivery. The commonwealth monitors program operations, including Service Coordination, Network Adequacy and provider qualifications, and assesses the performance of the plans through these reports.

Under the Community HealthChoices Program, the CHC-MCO must establish and implement a policy on referral of suspected Provider Fraud, Waste and Abuse to the Department.

The CHC-MCO is required to develop and implement administrative and management arrangements and procedures and a mandatory written compliance plan to prevent, detect, and correct Fraud, Waste, and Abuse that contains the elements described in CMS publication "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans".

The CHC-MCO must establish a Fraud, Waste and Abuse Unit comprised of experienced Fraud, Waste and Abuse reviewers. This Unit must have the primary purpose of preventing, detecting, investigating, referring, and reporting suspected Fraud, Waste and Abuse that may be committed by network providers, participants, caregivers, employees, or other third parties.

The CHC-MCO must inform all Network Providers of the Pennsylvania MA Provider Self Audit Protocol which allows providers to voluntarily disclose overpayments or improper payments of MA funds. The Department may impose sanctions or take other actions if it determines that a CHC-MCO, Network Provider, employee, caregiver or subcontractor has committed Fraud or Abuse.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the

amount of the limit. (check each that applies)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please see Module 1, Attachment #2 HCBS Settings Waiver Transition Plan for additional information. At the time of submission OLTL is gathering relevant information needed for compliance.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Service Coordinators will be responsible for the development of the service plan. Service Coordinators will be employed by or will be under contract with the CHC-MCO.

Service Coordinators and Service Coordinator Supervisors must meet the following qualifications:

- Service Coordinators must be a registered nurse (RN) or have a Bachelor's degree in social work, psychology or other related fields, or in lieu of a Bachelor's degree, have at least three (3) or more years of experience in a social service or health care related setting. Service Coordinators hired prior to the CHC zone Implementation Date must have the qualifications and standards proposed by the CHC-MCOs and approved by the department.
- Service Coordinator supervisors must be an RN or have a Master's degree in social work or in a human services or healthcare field and three years of relevant experience with a commitment to obtain either a Pennsylvania social work or mental health professional license within one year of hire. Service Coordinator supervisors hired prior to the CHC zone Implementation Date (who do not have a license) must either: 1) obtain a license within their first year under the new CHC contract in their zone or 2) have the qualifications and standards proposed by the CHC-MCOs and approved by the department.

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:*

CHC Service Coordinators are required to be conflict free as defined in 55 PA Code, Chapter 52.28 and 42 CFR 441.301(c)(1)(vi). A Service Coordination Entity may not provide other waiver services if the Service Coordination Entity provides service coordination services under contract with a CHC-MCO.

Service Coordination agencies may provide the following vendor services under an Organized Health Care Delivery System (OHCDS) only during the 180-day continuity of care period for each implementation phase:

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

Participants are not required to receive these 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 qualified provider that is part of the CHC-MCO's provider network. 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 willing and qualified providers that are part of the CHC-MCOs provider network, and electronically document evidence of participant choice. Service Coordinators are also responsible for providing participants with information and training on the process for selecting qualified providers of services during the PCSP development process using the provider directory which is maintained by the CHC-MCO.

Participants are also given the toll-free number of the CHC-MCO so they may contact their CHC-MCO should they have concerns about their providers or questions regarding their ability to choose providers that provide the services in their service plan. The CHC-MCO's toll-free number is provided to Participants at time of enrollment, at annual reevaluations, and during CHC Service Coordinator's participant service monitoring visits.

During the 180-day continuity of care period, the CHC-MCOs are responsible for oversight and monitoring to safeguard participants' choice of providers. At the end of each 180-day continuity of care period, the CHC-MCOs must have these types of providers enrolled as part of their provider network and ensure network capacity.

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.

a. The CHC-Service Coordinator provides information to the individual and to their representative, if any, in advance of the planning meeting so that he/she can make informed choices about their services and service delivery in order to effectively develop a person-centered service plan (PCSP). A PCSP is a written description of Participant-specific healthcare, Long-Term Services and Supports (LTSS), and wellness goals to be achieved, and the type, scope, amount, duration, and frequency of the covered services to be provided to a Participant in order to achieve such goals. Services and supports are based on the comprehensive needs assessment of the Participant's healthcare, LTSS and wellness needs. The PCSP will consider the current and unique psycho-social and medical needs and history of the participant, as well as the participant's functional level and support systems. The PCSP process must address the full array of medical and non-medical services needed by the Participant and supports provided by the CHC-MCO and available in the community to ensure the maximum degree of integration and the best possible health outcomes and participant satisfaction.

Prior to the PCSP meeting(s), the CHC Service Coordinator works with the participant and/or their representative to coordinate invitations and PCSP 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 CHC Service Coordinators provide Participants and their representative, if any, with a participant orientation packet within 5 days of enrollment. The packet contains information on participant rights and responsibilities; participant choice; the role of the CHC Service Coordinator; the role of the Person-Centered Planning Team (PCPT); participant complaints; appeals and fair hearings; how to connect to other community resources; abuse, neglect and exploitation; and fraud and abuse. The packet provides Participants with a basis for self-advocacy safeguards. 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 or an interpreter in accordance with Appendix B-8. In addition, the CHC Service Coordinator must educate the participant on the following:

- Strategies for solving conflict or disagreement within the PCPT process, including clear conflict-of-interest guidelines for all planning Participants;
- Offer informed choices to the participant regarding the services and supports they receive and from whom;
- A method for the participant to request updates to the PCSP as needed; and
- The Participant's due process and appeal rights when the Participant:
 - o is denied his or her request for a new Waiver-funded service(s), including the amount, duration, and scope of service(s),
 - o experiences a reduction in the amount, duration, and scope of services,
 - o is denied the choice of willing and qualified Waiver provider(s),
 - o experiences a decision or an action which denies, suspends, reduces, or terminates a Waiver-funded service authorized on the Participant's PCSP, or
 - o is involuntarily terminated from participant direction.

The CHC Service Coordinator provides Participants and/or their representative with information and training on services and supports available to the participant and the processes for selecting qualified providers of services. The CHC-MCO shall be required to provide its Participants with LTSS Provider directories upon request, which include, at a minimum, the following information:

- The names, addresses and telephone numbers of LTSS Providers;
- Identification of the services provided by each LTSS Provider listed;
- Identification of special services, languages spoken and communication competencies, etc.; and
- Experience or expertise in serving individuals with particular medical conditions or disabilities.

b. Person-Centered Service Planning is a process directed by the participant with long-term service and support needs. The Participant has the authority to include a representative who is authorized to make personal decisions for the participant. The Participant also has the authority to include family members, legal guardians, friends, caregivers, members of the PCPT, and any others the participant or his/her representative wishes to include. The person-centered service planning process helps to identify outcomes based on the participant's goals, interests, strengths, abilities, and preferences. The process assists the participant to articulate a plan for the future and helps determine the supports and services that the participant needs to achieve these outcomes. The CHC Service Coordinator is responsible to include all of those elements into the PCSP.

The PCPT approach must provide the necessary level of support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. The CHC-MCO must annually submit and obtain Department approval of its PCPT policy on PCSP development and implementation.

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):

a. Who develops the plan, who participates in the process and the timing of the plan:

The Participant will lead the PCPT. The PCSP process will also include individuals chosen by the Participant, who may include family members, legal guardians, friends, caregivers, and any others the participant or his/her representative wishes to include as members of the PCPT. The PCSP process helps to identify outcomes based on the participant's goals, interests, strengths, abilities, and preferences, as well as assists the participant to articulate a plan for the future and helps determine the supports and services that the participant needs to achieve these outcomes. The CHC Service Coordinator is responsible to include all of those elements into the PCSP.

Prior to the PCSP meeting(s), the CHC Service Coordinator works with the participant to coordinate invitations and PCSP/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 CHC Service Coordinator ensures that the PCSP is completed prior to services being delivered. The CHC Service Coordinator will initiate a process to re-evaluate the PCSP at least annually (at least once every 365 days) and when either there is a significant change in the Participant's situation or condition or the Participant requests re-evaluation. The CHC Service Coordinator ensures that the PCSP is updated, approved, and authorized as changes occur. The CHC Service Coordinator schedules the service planning meetings at times and places that are convenient to the participant. PCSPs must be completed no later than 30 days from the date the comprehensive needs assessment or reassessment is completed.

The CHC Service Coordinator gathers information on an ongoing basis to assure the PCSP reflects the participant's current needs. The CHC Service Coordinator discusses potential revisions to the PCSP with the Participant and individuals important to the Participant. All changes to existing PCSPs must be documented in the Participant's record.

Once the PCSP is authorized by the MCO, the CHC Service Coordinator communicates the service plan content to the Participant and to the Participant's appropriate service provider or providers to ensure that service delivery matches the approved PCSP.

b. The types of assessments that are conducted:

Part of the enrollment process involves the completion of clinical eligibility determination 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.

Once enrolled into CHC, the CHC Service Coordinator completes OLTL's standardized needs assessment which secures information about the participant's strengths, capacities, needs, preferences, health status, risk factors, physical health, behavioral health, social, psychosocial, environmental, caregiver, LTSS, and other needs as well as preferences, goals, housing, and informal supports. The comprehensive needs assessment and reassessment processes completed by the CHC-MCO must also capture the following:

- Need for traditional comprehensive care management of chronic conditions and disease management.
- Functional limitations, including cognitive limitations, in performing ADL and IADLs and level of supports required by the Participant.
- Ability to manage and direct services and finances independently.
- Level of supervision required.
- Supports for unpaid caregivers.
- Identification of risks to the Participant's health and safety.
- Environmental challenges to independence and safety concerns.
- Availability of able and willing informal supports.
- Diagnoses and ongoing treatments.
- Medications.
- Use of adaptive devices.
- Preferences for community engagement.
- Employment and educational goals.

Reassessments must be completed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, but in no case more than 14 days after the occurrence of any of the following trigger events:

- A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare

settings, or a hospital discharge.

- A change in functional status.
- A change in caregiver or informal support status if the change impacts one or more areas of health or functional status.
- A change in the home setting or environment if the change impacts one or more areas of health or functional status.
- A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning.
- As requested by the Participant or designee, the caregiver, the provider, the PCPT or a PCPT Participant, or the Department.

In addition to the trigger events listed above, if the CHC-MCO identifies that a participant has not been receiving services for five (5) or more consecutive service days to assist with activities of daily living as indicated on the service plan, and if the suspension of services was not pre-planned, then the CHC-MCO must communicate with the participant to determine the reason for the service suspension within 24 hours of identifying the issue. If the participant's health status or needs have changed, then the CHC-MCO must conduct a comprehensive needs reassessment of the participant's needs within fourteen (14) days of identifying the issue.

c. How the participant is informed of the services available under the waiver:

The PCPT is established to identify services based on the participant's needs and preferences, as well as availability and appropriateness of services. The CHC Service Coordinator describes and explains the concept of person-centered service planning, as well as the types of services available through the Waiver and other resources. The CHC Service Coordinator also provides detailed information (described further in Appendix E) regarding opportunities for participant-directed services and responsibilities for directing those services. These discussions between the CHC Service Coordinator and the Participant will be documented in the Participant's record.

d. How the process ensures that the service plan addresses participant's desired goals, outcomes, needs and preferences:

The CHC 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. In addition, CHC Service Coordinators ensure that the PCSP 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 CHC Service Coordinator, along with the PCPT, utilizes the assessments, documentation obtained from direct service providers 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 PCSP. This information is captured by the CHC Service Coordinator and then documented in the participant's record.

The CHC Service Coordinator reviews, in conjunction with the Participant, the Participant's services to ensure the services are adequate to meet the desired outcomes. Revisions are discussed with the Participant and incorporated into the PCSP. The Service Coordinator shares updated service information service providers. All service plan meetings and discussions with the participant are documented in the participant's record.

e. How responsibilities are assigned for implementing the plan:

The CHC-MCO must implement a written, holistic PCSP for each Participant who receives home and community-based services. The CHC-MCO must comply with the requirements specified in 42 CFR 441.301(c)(1)-(3) and any additional requirements established by OLTL in implementing the PCSP.

The PCSP must address how the Participant's physical, cognitive, and behavioral health needs will be managed, including how Medicare coverage (if the Participant is dual eligible) will be coordinated and, how the Participants' LTSS services will be coordinated. The holistic PCSP for LTSS Participants, at a minimum, must include the following:

- Active chronic problems, current non-chronic problems, and problems that were previously controlled or classified as maintenance care but have been exacerbated by disease progression or other intervening conditions.
- Current medications.
- All services authorized, and the scope, amount, duration and frequency of the services authorized, including any services that were authorized by the CHC-MCO since the last PCSP was finalized that need to be authorized moving forward.
- A schedule of preventive service needs or requirements.
- Disease management action steps.
- Known needed physical, cognitive and behavioral healthcare and services.

- All designated points of contact and the Participant's authorizations of who may request and receive information about the Participant's services.
- How the CHC Service Coordinator will assist the Participant in accessing Covered Services identified in the PCSP.
- How the CHC-MCO will coordinate with the Participant's Medicare, Veterans, BH-MCO, and other health coverage.

The PCSP for LTSS Participants must identify how their LTSS needs will be met and how their Service Coordinator will ensure that services are provided in accordance with the PCSP. The LTSS Service Plan section of the PCSP must include the following:

- All LTSS services necessary to support the Participant in living as independently as possible and remaining as engaged in their community as possible.
- Reflect that the setting in which the individual resides is chosen by the participant.
- For the needs identified in the comprehensive needs assessment, the interventions to address each need or preference, reasonable long-term and short-term goals, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes.
- Potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the Participant's maximum functioning level of well-being.
- Participant decisions around self-directed care and whether the Participant is participating in Participant-Direction.
- Communications plan.
- The scope, amount, duration and frequency that specific services will be provided.
- Whether and, if so, how technology and telehealth will be used.
- Participant choice of Providers.
- Individualized Back-Up Plan.
- Emergency Back-Up Plan.
- The person(s)/Providers responsible for specific interventions/services.
- Participant's available, willing, and able informal support network and services.
- Participant's need for and plan to access community resources and non-covered services, including any reasonable accommodations.
- How to accommodate preferences for leisure activities, hobbies, and community engagement.
- Any other needs or preferences of the Participant.
- Participant's goals for the least restrictive setting possible, if they are being discharged or transitioned from an inpatient setting.
- How the CHC-MCO will coordinate with the Participant's Medicare, Veterans, BH-MCO, other health coverage, and other supports.
- Participant's employment and educational goals.
- Emergency back-up plan.

The CHC Service Coordinator must obtain the signatures of the Participant, Participant's representative and any others involved in the planning process, indicating they participated in, approve and understand the services outlined in the PCSP and that services are adequate and appropriate to the participant's needs. A Participant may also sign indicating disapproval of the plan if the Participant disagrees with the PCSP. When this occurs, the Service Coordinator must provide the Participant with their due process and appeal rights. Every Participant must receive a copy of his/her PCSP. A copy of the signed PCSP is given to the participant as well as all members of the PCPT.

The CHC Service Coordinator, in conjunction with the Participant and PCPT, are responsible for updating the PCSP annually by performing the minimum following roles in accordance with specific requirements and time frames, as established by OLTL:

- Conducting the annual re-assessment at least once every 365 days and whenever the Participant's needs change;
- Documenting contacts with individuals, families and providers;
- Record keeping;
- 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;
- Assuring information is in completed PCSP;
- Participating in PCSP reviews;

- Coordinating recommended services; and
- Reviewing plan implementation.

The Service Coordinator must communicate the service plan content to the provider or providers to ensure that service delivery matches the approved PCSP. The Service Coordinator must provide an authorization of service that includes the type, scope, amount, duration, and frequency of services to be provided and any preferences the participant has related to service delivery.

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

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 CHC Service Coordinator 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. If a participant is not capable of notifying their Service Coordinator or initiating a back-up plan a family member, or the participant's representative, will be designated the responsibility to do so.

f. How waiver and other services are coordinated:

The CHC-MCO and Service Coordinator must coordinate all necessary Covered Services and other services for Participants. The CHC-MCO and Service Coordinator must provide for seamless and continuous coordination of services across a continuum of services for the Participant with a focus on improving healthcare outcomes and independent living. These activities should be done as part of Person-Centered Service Planning and the PCSP implementation process.

The CHC Service Coordinator supports the Participant in identifying and gaining access to a continuum of services including HCBS services, as well as needed medical, social, educational, and other services, regardless of the funding source. The PCPT 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 PCSP, which is distributed by the CHC Service Coordinator to the Participant, PCPT and providers of service. The CHC Service Coordinator is responsible for ensuring the ongoing coordination between services in the PCSP, as well as ensuring consistency in service delivery among providers.

g. The assignment of responsibility to monitor and oversee the implementation of the service plan:

CHC-MCOs are responsible for monitoring the implementation of the PCSP, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of participants. After the initiation of services identified in the Participant's PCSP, CHC-MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the PCSP. CHC-MCOs also identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively. CHC-MCOs must develop methods for prompt follow-up and remediation of identified problems; policies and procedures regarding required time frames for follow-up and remediation must be submitted to OLTL for review and approval. CHC-MCOs must report on monitoring results to OLTL. Furthermore, CHC-MCOs must annually submit and obtain OLTL approval of their Service Coordination staffing, Participant contact plan, caseloads, the required and the frequency of in-person contact with Participants. The CHC-MCO is responsible for on-going monitoring of PCSP implementation and of direct service providers. CHC-MCOs must conduct a formal administrative review annually for monitoring of direct service providers.

CHC Service Coordinators are responsible for documenting and monitoring at a minimum the following:

- The Participant is receiving the amount (units) of services that are in the PCSP.
- The Participant is receiving the frequency of services that are in PCSP.
- The participant receives the authorized services that are in the PCSP.
- The Participant is receiving the duration of services that are in the PCSP.

In addition, CHC service coordinators are responsible to use the standardized participant review tool designed by OLTL to capture information on Participants' health, welfare, and service needs in all HCBS settings. The tool also captures

information on provider owned and operated residential settings to assist in assessing compliance with the Centers for Medicare and Medicaid Services HCBS regulation found in 42 CFR § 441.301. The overall goal of the tool is to assist SCs in their role of improving the experience of care for participants.

OLTL will monitor the following, which is outlined 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.

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 PCSP process includes the identification of potential risks to the Participant.

CHC Service Coordinators initially assess risks through the standardized needs assessment that is completed during a face-to-face interview with the individual at the time of PCSP development. The CHC Service Coordinators summarize risks into categories according to health/medical, community, and behavioral risks. The CHC 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 PCSP. The CHC Service Coordinator, the PCPT, the Participant and any other individuals involved in the planning process will identify strategies to mitigate such risks that will allow Participants to live in the community while assuring their health and welfare. The Participant will sign a statement as part of the PCSP signature page agreement that indicates the CHC 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 person-centered service planning process.

The PCPT will develop both back-up plans to mitigate risks and priority arrangements to ensure the health, safety and welfare of the Participant during the PCSP development process. Back-up plans are also part of the ongoing service plan monitoring process at the CHC Service Coordinator level. All Participants are required to have individualized back-up plans and arrangements to cover services they need when the regularly scheduled direct care 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 back-up plan fails, Participants may utilize the agency model to provide back-up coverage to meet their immediate needs. The CHC Service Coordinator may reach out to and utilize other home health or home care agencies for back-up if necessary and document the details in the PCSP. In addition, the PCSP must incorporate an emergency back-up plan (emergency preparedness plan) for serious emergencies that might cause a disruption in routine services being delivered to the participant for an extended period of time. Examples include severe storms, floods, or any type of community-wide disaster that may require an evacuation from the Participant's home or require the Participant to 'shelter in place' for a period of several days. The CHC Service Coordinator is responsible during regular monitoring to validate that the strategies and back-up plans are working and are still current. To assist in assuring the health and welfare of the individuals, Participants are instructed to contact the CHC Service Coordinators to report disruptions of back-up 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.

The CHC-MCO shall be required to provide its Participants with LTSS Provider directories in paper and electronic form upon request, which include, at a minimum, the following information:

- The names, addresses and telephone numbers of LTSS Providers;
- Identification of the services provided by each LTSS Provider listed;
- Identification of special services, languages spoken and communication competencies, etc.; and
- Experience or expertise in serving individuals with particular conditions.

The CHC 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 CHC Service Coordinator will electronically document evidence of participant choice.

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

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):

Services may not be reduced or terminated in the absence of an up-to-date assessment of needs that supports the reduction or termination. The CHC-MCO must provide OLTL with monthly aggregate and participant-level reports on PCSP changes. OLTL may review, question and request the revisions of any PCSP.

Any deficiencies or issues identified through the review of the PCSP will be presented to the CHC MCO for remediation. The CHC-MCO will be notified through communication from OLTL staff. In the event of non-compliance with PCSP requirements and timelines, the CHC-MCO must outline a corrective action plan that addresses how and when the CHC-MCO will do the following:

- Immediately remediate all individual findings identified through the monitoring process;
- Track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance;
- Implement strategies to improve community-based Service Coordination processes and resolve areas of non-compliance or participant dissatisfaction; and
- Measure the success of such strategies in addressing identified issues.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

--

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

CHC-MCO

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.

CHC-MCOs are responsible for monitoring the implementation of the PCSP, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of participants. CHC-MCOs also shall identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively. CHC-MCOs must develop policies and procedures, including time frames, for prompt follow-up and remediation of identified problems. These policies and procedures must be submitted to OLTL for review and approval. At a minimum, the CHC service coordinators are responsible to use the standardized participant review tool designed by OLTL to capture information on Participants' health, welfare, and service needs in all HCBS settings. The tool also captures information on provider owned and operated residential settings to assist in assessing compliance with the Centers for Medicare and Medicaid Services HCBS regulation found in 42 CFR § 441.301. The overall goal of the tool is to assist Service Coordinators in their role of improving the experience of care for participants.

CHC-MCOs must report on monitoring results to OLTL. Furthermore, CHC-MCOs must annually submit and obtain OLTL approval of their Service Coordination staffing, Participant contact plan, caseloads, the required and the actual frequency of in-person contact with Participants. At a minimum, the CHC-MCOs' Service Coordinators must meet with waiver participants at least once every three months by phone or in-person to assure that a Participant's LTSS are meeting their needs. At least two 2 of these visits must be in-person every year. The CHC-MCO is responsible for on-going monitoring of PCSP implementation and of direct service providers. CHC-MCOs must conduct a formal administrative review annually for monitoring of direct service providers. The CHC-MCO must also submit policies and procedures regarding required time frames for follow-up and remediation to OLTL for review and approval

OLTL will monitor the following, which is outlined 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.

In addition, the Fiscal/Employer Agent (F/EA) assists both the CHC-MCOs and their Service Coordinators 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, the CHC-MCO, and CHC service coordinators, 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 CHC Service Coordinator of any common law employer who does not submit time sheets 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:*

CHC Service Coordinators are required to be conflict free as defined in 55 PA Code, Chapter 52.28 and 42 CFR 441.301(c)(1)(vi). A Service Coordination Entity may not provide other waiver services if the Service Coordination Entity provides service coordination services under contract with a CHC-MCO.

Service Coordination agencies may provide the following vendor services under an Organized Health Care Delivery System (OHCDS) only during the 180-day continuity of care period for each implementation phase:

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

Participants are not required to receive these 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 qualified provider that is part of the CHC-MCO's provider network. 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 willing and qualified providers that are part of the CHC-MCOs provider network, and electronically document evidence of participant choice. Service Coordinators are also responsible for providing participants with information and training on the process for selecting qualified providers of services during the PCSP development process using the provider directory which is maintained by the CHC-MCO.

Participants are also given the toll-free number of the CHC-MCO so they may contact their CHC-MCO should they have concerns about their providers or questions regarding their ability to choose providers that provide the services in their service plan. The CHC-MCO's toll-free number is provided to Participants at time of enrollment, at annual reevaluations, and during CHC Service Coordinator's participant service monitoring visits.

During the 180-day continuity of care period, the CHC-MCOs are responsible for oversight and monitoring to safeguard participants' choice of providers. At the end of each 180-day continuity of care period, the CHC-MCOs must have these types of providers enrolled as part of their provider network and ensure network capacity.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:

SP-1: Number and percent of CHC waiver participants who have Person-Centered Service Plans (PCSPs) adequate and appropriate to their needs, capabilities, and desired outcomes

Numerator: Total number of CHC waiver participants who have PCSPs adequate and appropriate to their needs, capabilities, and desired outcomes

Denominator: Total number of CHC waiver participants who had PCSPs reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligations and validated by OLTL.

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 = <div>95% +/- 5%</div>
Other Specify: <div>CHC-MCO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div>Bi-Annually</div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

Performance Measures

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

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

- c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.**

Performance Measures

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

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

Performance Measure:

SP-3: Number and percent of CHC waiver participants with Person-Centered Service

Plans (PCSPs) revised when warranted by a change in participants needs.

Numerator: Total number of CHC waiver participants with PCSPs that were revised when warranted by a change in participant's needs. Denominator: Total number of CHC waiver participants who had PCSPs reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligation and validated by OLTL.

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 = <div>95% +/-5% margin of error</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div>Bi-Annually</div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

SP-2: Number and percent of CHC waiver participants with Person-Centered Service Plans (PCSPs) reviewed before the waiver participant's annual review date

Numerator: Total number of CHC waiver participants with PCSPs that were reviewed before the waiver participant's annual review date
Denominator: Total number of CHC waiver participants who had PCSPs reviewed

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligations and validated by OLTL.

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

		95% +/-5% margin of error
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

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

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

Performance Measure:

SP-4: Number and percent of CHC waiver participants who have received authorized services in the type, scope, amount, frequency, and duration specified in the Person-Centered Service Plan (PCSPs)
Numerator: Number of CHC waiver participants who are receiving services specified in the Person-Centered Service Plan (PCSP)
Denominator: Total number of CHC waiver participants who had PCSPs reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligation and validated by OLTL.

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 = <div>95% +/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify:	

	Bi-Annually	
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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: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

SP-5: Number and percent of CHC waiver participants whose records documented an opportunity was provided for choice of waiver services and providers
Numerator: Number of CHC waiver participants with documented evidence of opportunities
Denominator: Total number of CHC waiver participants who had PCSPs reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligation and validated by OLTL.

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 = <div>95% +/- margin of error</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div>Bi-Annually</div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- 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.

CHC-MCOs are responsible for monitoring the implementation of the PCSP, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of participants. After the initiation of services identified in the Participant's PCSP, CHC-MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the PCSP. CHC-MCOs also identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively. CHC-MCOs will provide prompt follow-up and remediation of identified problems; as stipulated in the CHC-MCO policies and procedures submitted to and approved by OLTL according to the terms of the CHC-MCO contract. CHC-MCOs must report on monitoring results to OLTL. The CHC-MCO is responsible for on-going monitoring of PCSP implementation and of direct service providers. The Service Coordinator prepares, and the SC supervisor reviews, the PCSP to ensure the PCSP meets the identified needs of the participant and will submit it to the MCO for authorization. CHC-MCO's will collect and submit data reports to the Bureau of Coordinated and Integrated Services on information pertaining to service plan appropriateness and conformity to participant need. The CHC-MCO shall audit a Department-approved size sample of the PCSPs to demonstrate compliance with the requirements of the Quality Management /Utilization Management (QM/UM) program. Audit results are submitted to the Department as part of the Annual QAPI Program Evaluation. The Department may review, question, and request the revisions of any Person-Centered Service Plan. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes.

The Bureau of Coordinated and Integrated Services reviews, provides analysis, and tracks the data submitted by MCOs, and ensures sample size for a statistically valid sample using CMS sampling parameters. See Appendix H for more information on quality performance.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States 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.

After the initiation of services identified in the Participant's PCSP, CHC-MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the PCSP. CHC-MCOs also identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively. CHC-MCOs will provide prompt follow-up and remediation of identified problems; as stipulated in the CHC-MCO policies and procedures submitted to and approved by OLTL according to the terms of the CHC-MCO contract. CHC-MCOs must report on monitoring results to OLTL. The CHC-MCO is responsible for on-going monitoring of PCSP implementation and of direct service providers. CHC-MCOs provide weekly, monthly and annual data reports to OLTL. The Bureau of Coordinated and Integrated Services staff tracks the sample size to ensure a statistically valid sample using CMS sampling parameters and provides analysis based on data submitted by MCOs. When issues are identified, OLTL will initiate meetings with the CHC-MCOs to provide information about performance, submit information to the CHC-MCOs in writing asking them to remediate the issue, and when necessary, issue a Corrective Action Plan for compliance. See Appendix H for more information on quality performance.

ii. Remediation Data Aggregation

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

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

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 CHC Waiver:

All participants have the option to make decisions about and self-direct their own waiver services as identified in Section E-1.g., below. Participants in the CHC Waiver may choose to hire and manage staff using Employer Authority or manage an individual budget using Budget Authority. In addition, participants may choose a combination of service models to meet their individual needs. Participants are encouraged to self-direct their services to the highest degree possible. During the actual provision of services, the participant is responsible for directing the activities of their support worker.

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

How Participants May Take Advantage of Self-Directed Opportunities:

Participants may choose to self-direct certain services during the development of the person-centered service plan (PCSP), 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 self-directed opportunities within the waiver. The CHC-MCO will provide all waiver participants with information about self-direction as part of the member handbook and orientation materials. Materials must be written at a level that is easily understood using everyday common language to ensure accessibility, and in alternate formats as needed by the participant.

As stated previously, the participant may utilize a combination of any model(s) to personalize their PCSP. The PCSP is developed in conjunction with the Service Coordinator and the waiver participant, as described in Appendix D, to ensure that the participant's service needs are met, and reflects the participant's choice of model of service. Service Coordinators shall offer provider-managed services to all participants who have chosen to self-direct their services until the individual's support workers are hired. Participants may elect to change their service model at any time by notifying their Service Coordinator. Service Coordinators must work with participants to ensure they do not experience a disruption in services when participants choose to change service models.

Entities That Support Individuals:

Participants will receive a full-range of supports, ensuring that they are successful with the participant-directed experience. Individuals choosing Employer or Budget Authority will receive support from certified Vendor Fiscal/Employer Agents (F/EA) and Service Coordinators to assist them in their role as the common-law employer of their workers. The F/EA will:

- Enroll participants in Financial Management Service (FMS) and apply for and receive approval from the IRS to act as an agent on behalf of the participant;
- Provide orientation and skills training to participants or their representative on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; 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 PCSP;
- 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 the CHC-MCO on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and the CHC-MCO (Budget Authority only).

In addition, individuals choosing to self-direct their services will receive assistance from their Service Coordinator to develop their person-centered service plan. Once the PCSP 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 PCSP, 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. This includes a review of workplace safety issues and strategies for effective management of workplace injury prevention;
- Recommend or arrange training on the topics of abuse, neglect, exploitation and abandonment as defined by protective services statutes;
- Monitor the provision of services to ensure the Participant's health and welfare; 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 implement, modify and manage the Spending Plan. The Service Coordinator will review and approve the participant's Spending Plan. 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 participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

The Participant's Service Coordinator is responsible for presenting all available service options and ensuring that each participant understands the full range of participant-direction opportunities within the waiver. The Service Coordinator documents the participant's choice of service delivery model on the PCSP. 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, annually during the PCSP annual review meeting and upon request.

The CHC-MCOs or the F/EA shall develop 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 are available on the CHC-MCOs' or the F/EA's website. In addition, the CHC-MCOs will provide all waiver participants with information about self-direction as part of the Participant Handbook and orientation materials. This information will be shared with individuals upon enrollment, at monitoring contacts and during annual PCSP updates each year thereafter. Orientation materials must be written at a level that is easily understood using everyday common language to ensure accessibility, and in alternate formats as needed by the participant. In addition, orientation materials are provided in advance of the PCSP meeting to ensure that individuals have sufficient time to consider their options and the responsibilities.

The F/EA is responsible for providing orientation and training to the participant prior to employing their direct care worker. Orientation is based upon a standard curriculum developed by the CHC-MCOs or the F/EA, approved by OLTL and includes, at minimum, the following:

- Review of the information and forms contained in both the Employer and Direct Care Worker enrollment packets and how they should be completed;
- The role and responsibilities of the common law employer;
- The role and responsibilities of the F/EA;
- The process for receipt and processing timesheets and employee payroll checks;
- The process for resolving issues and complaints; and
- Workers Compensation and the process for reviewing workplace safety issues and strategies for effective management of workplace injury prevention.

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

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

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

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

Waiver services may be directed by a non-legal representative freely chosen by an adult participant or for any individual who is unable to:

- Understand his/her own personal care needs
- Make decisions about his/her own care
- Manage his/her lifestyle and environment by making these choices
- Understand or have the ability to learn how to recruit, hire, train, and supervise providers of care; or
- Understand the impact of his/her decisions and assume responsibility for the results.

When circumstances indicate a change in the participant's ability to self-direct or when the participant demonstrates misuse of funds, consistent non-adherence to program policy or an ongoing health and welfare risk, the Service Coordinator will convene the Person-Centered Planning Team (PCPT) to explore the appointment of a representative.

A personal representative may be a legal guardian, or other legally appointed personal representative, an income payee, a family member, or friend. The personal representative must be willing and able to fulfill the responsibilities as outlined in the Personal Representative Agreement and must demonstrate:

- A strong personal commitment to the participant;
- Assist the participant in identifying/ obtaining back up services when a support worker does not show;
- Demonstrate knowledge of the participant's preferences;
- Agree to predetermined frequency of contact with the participant as mutually determined by the participant, the personal representative and the Service Coordinator; and
- Be at least 18 years of age.

A representative may not be a paid support service worker for the participant.

The F/EA must recognize the participant's personal representative as a decision-maker, and provide the personal representative with all of the information, training, and support it would typically provide to a participant who is self-directing. The F/EA must fully inform the personal representative of the rights and responsibilities of a representative. Once informed, the F/EA must have the representative review and sign the standard Common Law Employer Designation form, which must be given to the representative and maintained in the participant's file. The agreement lists the roles and responsibilities of the representative; states that the representative accepts the roles and responsibilities of this function; and states that the representative will abide by OLTL policies and procedures.

The Service Coordinator is responsible for ensuring the personal representative functions in the best interest of the participant through, at minimum, quarterly monitoring calls, by monitoring the personal representative's adherence to the Common Law Employer Designation form, and ensuring services are being provided as outlined in the participant's PCSP. When it appears the personal representative is not acting in the best interest of the participant, and there has been a negative impact on the participant's health and welfare and/or services have not been provided as outlined in the PCSP, the Service Coordinator and PCPT must explore other alternatives, such as appointing a new personal representative or transitioning the participant to the provider managed service delivery model as described in Appendix E-1-m below. The Service Coordinator is also required to report any incidents of suspected abuse, neglect and/or exploitation as described in Appendix G.

In addition, the F/EA is required to address and report any issues identified with the representative, and adhere to OLTL policy on incident reporting and report any incident of suspected fraud or abuse.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Participant-Directed Goods and Services		

Waiver Service	Employer Authority	Budget Authority
Participant-Directed Community Supports		
Personal Assistance Services		
Respite		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

Governmental entities

Private entities

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Services are provided to participants across the Commonwealth by qualified Fiscal Employer Agent(s). The CHC-MCOs are responsible for Fiscal/Employer Agent (F/EA) functions and must process, file, and pay all state and federal taxes on behalf of participants and their direct service workers. The CHC-MCOs must operate as a Vendor Fiscal/Employer Agent (F/EA) or subcontract this function. The F/EA is required by contract to operate in accordance with Section 3504 of the Internal Revenue Code, per Revenue Procedure 70-6 and Section 3504 Agent Employment Tax Liability proposed regulations (REG-137036-08) issued by the IRS on January 13, 2010. The F/EA must meet all applicable Participant Direction-related Federal and State requirements. The CHC-MCO must meet all additional requirements as stated in the CHC Agreement.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment for Financial Management Services will be made by the CHC-MCO.

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:

Assist participant in verifying support worker citizenship status**Collect and process timesheets of support workers****Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance****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, state, and local tax forms; the completion of timesheets; 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;
- Compute, withhold, file, and deposit federal, state and local income taxes in accordance with all federal IRS and state Department of Revenue rules and regulations;
- Broker workers' compensation for all support workers through the appropriate agency;
- Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws;
- Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually;
- Assist in implementing the state's quality management strategy related to FMS
- Establish an accessible customer service system for the participant and the Service Coordinator.
- Assist participants in verifying support workers citizenship or alien status; and
- Provide written financial reports to the participant, the Service Coordinator and the CHC-MCO on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and CHC-MCO.

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget**Track and report participant funds, disbursements and the balance of participant funds****Process and pay invoices for goods and services approved in the service plan****Provide participant with periodic reports of expenditures and the status of the participant-directed budget****Other services and supports***Specify:*

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

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

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

The CHC-MCOs will monitor the F/EA annually to ensure that the contract deliverables are met, and participants are in receipt of Financial Management Services in accordance with their PCSP. The CHC-MCOs 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 of processing employer and employee paperwork, timeliness of 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. It will also include timeliness of criminal background checks and child abuse clearances as needed. If the F/EA is not in compliance with contractual or waiver provisions, the CHC-MCOs will identify and remediate any noncompliance. The CHC-MCOs 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. The CHC-MCOs will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary. CHC-MCOs will also be required to report on the FMS organization's performance to OLTL via an identified operations report.

In the event the CHC-MCOs do not contract with a Vendor Fiscal/Employer Agent and serve as the F/EA, OLTL would conduct all monitoring activities consistent with the requirements above.

Lastly, the CHC-MCOs or the F/EA will conduct a Common Law Employer Satisfaction Survey using the survey tool approved 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 CHC-MCOs or the F/EA, and a report must be prepared and submitted to OLTL based upon specifications determined by the Department.

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
Home Delivered Meals	
Personal Emergency Response System (PERS)	
Counseling Services	
Specialized Medical Equipment and Supplies	
Career Assessment	
Participant-Directed Goods and Services	
Speech and Language Therapy Services	
Community Integration	
Benefits Counseling	
Nursing Services	
Community Transition Services	
Nutritional Consultation	
Assistive Technology	
Home Health Aide Services	
Participant-Directed Community Supports	
Occupational Therapy Services	
Job Finding	
Vehicle Modifications	
TeleCare	
Behavior Therapy	
Job Coaching	
Physical Therapy Services	
Cognitive Rehabilitation Therapy Services	
Non-Medical Transportation	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Adaptations	
Personal Assistance Services	
Pest Eradication	
Residential Habilitation	
Structured Day Habilitation Services	
Employment Skills Development	
Respite	
Adult Daily Living	

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 F/EA will be paid directly by the CHC-MCOs.

Participants will obtain enrollment and informational materials from the CHC-MCO or selected F/EA organization under contract with the CHC-MCO. In addition, the CHC-MCO or F/EA is responsible for providing orientation and training to the participant prior to employing their direct care worker. Orientation is based upon a standard curriculum approved by OLTL and includes the following:

- Review of the information and forms contained in both the Employer and Direct Care Worker enrollment packets and how they should be completed
- The role and responsibilities of the common law employer;
- The role and responsibilities of the F/EA;
- The process for receipt and processing timesheets and employee payroll checks;
- The process for resolving issues and complaints; and
- The process for reviewing workplace safety issues and strategies for effective management of workplace injury prevention.

Any required updates to the orientation curriculum must also be approved by OLTL.

Individuals choosing to self-direct their services will also receive assistance and support from their Service Coordinator. The Service Coordinator will:

- Provide participants with information regarding self-direction on an ongoing basis, including information about responsibilities, rights and concepts of self-direction;
- Work with the F/EA and the participant as necessary to ensure all enrollment and employment paperwork is completed and sent to the F/EA;
- Assist the participant 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;
- Recommend or arrange training on the topics of abuse, neglect, exploitation and abandonment as defined by protective services statutes;
- Assist the participant in communicating with the F/EA as needed;
- Monitor under-utilization and over-utilization and contact the participant and the CHC-MCO to resolve potential service delivery problems
- 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 PCSP process;
- 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 CHC-MCOs will monitor the F/EA annually to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their PCSP. The CHC-MCOs 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 of processing employer and employee paperwork, timeliness of 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, the CHC-MCOs will identify and remediate any noncompliance. The CHC-MCOs 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. The CHC-MCOs will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary. CHC-MCOs will also be required to report on the FMS organization's performance to OLTL via an identified operations report.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Participants have the option to transition from participant-directed services to the provider-managed service delivery model at any time by contacting their Service Coordinator who will guide them through the process of transition. The Service Coordinator is responsible for transitioning the participant to the traditional model of service and ensuring that there is not a break in service during the transition period, and supports are in place.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

OLTL will require participants, or personal representatives, who demonstrate the inability to self-direct their services whether due to misuse of funds, consistent non-adherence to program policy or an on-going health and welfare risk, to transition to provider-managed services.

Involuntary Termination from participant direction may also occur after the CHC-MCO determines 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 PCSP. The Service Coordinator may recommend involuntary termination, but the Service Coordinator must exhaust all available supports, such as appointing a personal representative, before recommending involuntary termination.

In any event, involuntary termination would only occur after a thorough review of the participant's health and welfare needs as identified in the service plan and 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 CHC-MCO.

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.

In the event of termination, the participant has the right to an appeal and, subsequently, a State 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	<input type="text"/>	<input type="text" value="288"/>
Year 2	<input type="text"/>	<input type="text" value="326"/>
Year 3	<input type="text"/>	<input type="text" value="15633"/>
Year 4	<input type="text"/>	<input type="text" value="24100"/>
Year 5	<input type="text"/>	<input type="text" value="25914"/>

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

To ensure all participants make an informed choice of service and service delivery, criminal background checks are mandatory for individuals performing personal assistance services. The CHC-MCO or the subcontracted F/EA secures and pays for the criminal background check as described in Appendix C-2-a. In addition, child abuse clearances are required for all direct care workers providing services in homes where minor children reside. Please see Appendix C-2-b for additional information.

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.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

n/a

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- 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 Person-Centered Service Plan (PCSP). The amount of the individual budget is based on the amounts of service that are authorized in the PCSP and are reflected in a participant's Spending Plan. The process for PCSP development is the same for all participants in the CHC Waiver, regardless of service model. The Service Coordinator reviews the participant's needs with the participant and ensures that the PCSP includes sufficient and appropriate services and provides the support that an individual needs or is likely to need in the home and community and to avoid institutionalization. Once the participant determines that they wish to self-direct, the number of units of Personal Assistance and Respite Services are multiplied by the rate for Personal Assistance Services that has been established by the CHC-MCO. This resulting 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 F/EA service fee are not included in the participant's individual budget amount and is not reflected in the participant's Spending Plan.

The Service Coordinator is responsible for explaining the method for developing the individual budget and sharing the budget amount with the participant during the PCSP 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 also identifies the timing for spending throughout the timeframe of the participant's plan. The F/EA must pay the invoices in accordance with the Spending Plan as authorized by the participant.

Information about participant-directed services, including the method for determining the individual budget, is made available through the SMW training manual, online and the standard participant information materials developed by the CHC-MCOs or the F/EA and approved 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 PCSP process, the Service Coordinator notifies the participant of the individual budget amount. 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 the CHC-MCO 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 PCSP. Funds in the participant's Spending Plan may be reallocated without modifying the PCSP 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 within three days of 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 PCSP and the Service Coordinator's submission to the CHC-MCO for approval prior to implementation. To initiate a change of this scope, the participant must meet with his/her Service Coordinator to amend their PCSP 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 the CHC-MCO on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and the CHC-MCO. The participant, Service Coordinator and CHC-MCO will receive written notification from the F/EA when utilization exceeds the monthly budget by 10% or more or when monthly utilization is 80% or less. If those events occur three times over 12 consecutive months, then the CHC-MCO may terminate the consumer-directed services after following the process of involuntary termination outlined in E-1-m.

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 the CHC-MCO 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. As stated before, this waiver application operates concurrently with an application to operate a managed care payment system for LTSS (i.e., CHC). A participant in CHC will have his or her rights to file a fair hearing request discussed as follows: at the time of enrollment, after enrollment, annually during the PCSP annual review meeting, and at any time the participant requests to change services or add new services.

At the time of application, the IEB is required to provide general information on due process and appeal rights to the applicant utilizing OLTL issued standard forms. A denial notice with appeal rights will be provided to applicants by the IEB if they do not complete the waiver application process, by OLTL if they do not meet the clinical or program eligibility requirements, or by the County Assistance Office (CAO) if they do not meet the financial eligibility requirements. The applicant has 30 calendar days from the mailing date of the written notifications to file an appeal.

In the event the applicant is enrolled into the waiver, the CHC-MCO is required to have a complaint and grievance system in compliance with 42 CFR Part 438, Subpart F. An enrolled participant may request a State Fair Hearing only after exhausting the CHC-MCO's complaint and grievance process referenced in the CHC 1915(b) waiver. Upon determining that it will uphold an adverse benefit determination, the CHC-MCO is required to utilize Department issued standard forms to provide information on how the participant may appeal the CHC-MCO's decision by requesting a State Fair Hearing. A participant has 120 calendar days from the date of the CHC-MCO's notice of adverse resolution to request a State Fair Hearing. A participant may request a State Fair Hearing any time the following circumstances occur:

1. The participant is not given the choice of home or community-based waiver services, including the Living Independence for the Elderly (LIFE) program for individuals aged 55 and over, as an alternative to institutional care.
2. The individual is denied his or her preference of waiver, LIFE 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 experiences a reduction in the amount, duration and scope of services.
5. The participant is denied the choice of willing and qualified waiver provider(s).
6. The participant is denied the opportunity to self-direct their services.
7. 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.

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 (BHA) for action.

It is the responsibility of the CHC-MCO and the IEB to provide any assistance the participant/applicant needs to request a hearing. The IEB provides assistance during the enrollment process and the CHC-MCO provides assistance after the participant has been enrolled. 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 spokesperson 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 CAO. The conflict-free entity making the Functional Eligibility Determination is required to participate in preparation for the hearing and at the hearing whenever an applicant appeals the clinical eligibility determination as part of the application process. CHC-MCOs are expected to participate when the Department sends a notice confirming the annual Functional Eligibility Redetermination and the individual appeals that notice.

CHC-MCOs will submit reports to OLTL as outlined in Program Requirements, documenting the appeals filed, reasons for the appeal and results of the hearing.

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.

The concurrent 1915(b) waiver application describes the complaint and grievance process required of the CHC-MCO.

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:

OLTL operates a customer service line to address callers' concerns.

- 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).

In addition to the MCO grievance process described in the concurrent 1915(b) waiver application, OLTL operates a Customer Service line, also known as the OLTL Participant HelpLine. The OLTL Participant HelpLine (1-800-757-5042) is located in the Bureau of Fee for Service Programs and is staffed by OLTL personnel during normal business hours. Participants, family members and other interested parties use the Participant 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 Participant 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. In addition, any reports of alleged abuse, neglect or exploitation of a participant are immediately referred to the appropriate protective services agency as described in Appendix G.

Investigations of Urgent complaints must be initiated within one business day, while Non-Urgent complaints have a five-day timeframe for complaint initiation of the investigation. Any complaint determined to be an incident as described in Appendix G will be handled in accordance with all applicable requirements. The receiving Bureau contacts the participant, their CHC 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.

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 (OLTL) has developed 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. The Bureau of Coordinated and Integrated Services (BCIS) is responsible for oversight of the Incident Management process.

Definitions of the types of critical events or incidents that must be reported:

As defined in Title 55 Pa. Code, Chapter 52, the following are considered critical incidents:

1. Death (other than by natural causes) – a death that is suspicious or of unexplained causes is a critical incident. A death due to natural causes is not a critical incident;
2. Serious Injury – an injury that results in emergency room visits, hospitalizations, or death;
3. Hospitalization – for a non-routine medical condition that was not scheduled or planned to occur is a critical incident; a routine planned hospital visit for lab work or routine planned treatment of illness of a participant is not a critical incident;
4. Provider and staff misconduct – deliberate, willful, unlawful, or dishonest activities;
5. Abuse – the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse are, but not necessarily limited to:
 - Physical abuse – defined as a physical act by an individual that may cause physical injury to a participant;
 - Psychological abuse – an act, other than verbal, that may inflict emotional harm, invoke fear, and/or humiliate, intimidate, degrade or demean a participant;
 - Sexual abuse – an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant; and
 - Verbal abuse – using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant.
6. Neglect – the failure to provide a participant the reasonable care that he, or she requires, including, but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm. Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect.
7. Exploitation – the act of depriving, defrauding, or otherwise obtaining the personal property from a participant in an unjust, or cruel manner, against one's will, or without one's consent, or knowledge for the benefit of self, or others;
8. Restraint – Any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. The use of restraints and seclusion are both restrictive interventions, which are defined as actions or procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights.
9. Service Interruption – Any event that results in the participant's inability to receive services that places his, or her health, and/or safety at risk. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization.
10. Medication errors that result in hospitalization, an emergency room visit or other medical intervention.

Individuals/entities that are required to report critical events:

Per 55 Pa. Code, Chapter 52 and OLTL's Critical Incident Management Bulletin, administrators and employees of LTSS providers, including CHC-MCO's, Service Coordinators, and individual providers of waiver services, are responsible for reporting critical incidents through the electronic Enterprise Incident Management system (EIM), an electronic data system that collects information regarding critical incidents involving waiver participants. In addition, Direct Service providers are required to notify the participant's Service Coordinator when a critical incident occurs.

In the event administrators, employees of LTSS and waiver service providers, including CHC-MCO's, Service Coordinators, and individual providers of waiver services have reasonable suspicion that a participant age 60 and over is the victim of a crime, including abuse, neglect, exploitation, or abandonment, or that death is suspicious, the provider must also report under the Older Adults Protective Services Act (OAPSA) (35 P.S. §§ 10225.101 – 10225.5102 and Title 6 Pa. Code, Chapter 15) and follow reporting requirements to the local protective service agency under the Department of Aging. In the event Direct Service providers, Service Coordinators or CHC-MCO's, have reasonable suspicion that a participant between the ages of 18 to 59 is the victim of abandonment, abuse, exploitation, intimidation, neglect, serious injury or bodily injury or sexual abuse, the provider must report under the Adult Protective Services Act (Act 70 of 2010) to the Department of Human Services' APS Hotline. For both OAPSA and APS, the provider must also inform the participant's Service Coordinator within 24 hours of knowledge of the incident. For both OAPSA and APS, the Direct Service provider, Service Coordinator and CHC-MCO's, must also immediately contact the appropriate law enforcement official to file a report when incidents involve sexual abuse, serious injury, serious bodily injury or suspicious death. These additional reporting requirements do not supplant a provider's reporting responsibilities through EIM.

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.

Time frames within which critical events must be reported and the methods for reporting:

Required reporters must report critical incidents 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, allows Direct Service providers to submit critical incidents through a web-based application where they are accessed by Service Coordinators, the CHC-MCOs and OLTL staff.

Reporters are notified through EIM that their incident reports have been received. CHC-MCO staff will review the critical incidents daily to ensure the health and welfare of participants, to check for completeness and to ensure that what has been reported is truly a critical incident. CHC-MCOs will 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.

Within five days of enrollment, the CHC-MCO informs participants of the incident management process. This information is provided through the participant information materials developed by the CHC-MCO's and reviewed and approved by OLTL. These materials include how to recognize and report abuse, neglect and exploitation, as well as the prohibition on the use of restraints, seclusion and other restrictive interventions. In addition, the information includes the process for reporting these occurrences to the participant's Service Coordinator 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. Participants are also provided with information on reporting directly to APS and OAPSA.

- 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.

The CHC-MCOs receive incident reports through EIM, the CHC-MCO's internal Participant Hotline 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 CHC-MCO is responsible for evaluating incident reports to ensure that the Direct Service 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, suspending the alleged perpetrator or referring to a victim's assistance program. The CHC-MCO also ensures that the provider meets the additional reporting requirements of the Department of Aging's Older Adult Protective Services Act (35 P.S. §§ 10225.101 – 10225.5102 and Title 6 Pa. Code, Chapter 15), the Department of Human Services' Adult Protective Services Act (Act of October 7, 2010, P.L. 484, No. 70) and/or the Department of Health when applicable.

The CHC-MCO reviews each incident as documented by the reporter to ensure that the report is complete. The CHC-MCO is responsible for investigation of incidents. Once all information is gathered, the CHC-MCO reviews the incident, and 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.

OLTL is responsible for reviewing and investigating all allegations of abuse, neglect, or exploitation that identify the CHC-MCO and/or their staff as the alleged perpetrator. OLTL retains the right to review any incident reports, conduct its own investigations and require further corrective actions by the CHC-MCO.

The entity that is responsible for conducting investigations and how investigations are conducted.

The CHC-MCO is responsible for conducting an investigation of incidents. An investigation includes taking the steps necessary to determine if a critical incident has occurred, determining if suspected abuse, neglect, abandonment or exploitation requiring the involvement of protective services is involved, what actions are needed to protect the health and welfare of participants and what actions are needed to mitigate future incidents. The Service Coordinator has two (2) days to enter initial information into EIM in cases involving sexual abuse, serious injury, serious bodily injury or suspicious death, and thirty (30) days from the initial report to enter all the information regarding the incident into EIM.

If the incident meets the standards of 35 P.S. §§ 10225.101 – 10225.5102, Title 6 Pa. Code, Chapter 15) 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 time frames.

Investigations that are performed by the CHC-MCOs include, but are not limited to:

- 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 are 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.

CHC-MCOs 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 EIM within the time frames 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 thirty (30) business days of the occurrence. When the CHC-MCO is unable to conclude initial investigation within thirty (30) days, request an extension from OLTL through EIM.

In cases investigated involving protective services, the CHC-MCO Service Coordinator works with the protective service worker to ensure the health and welfare of the participant. This may involve revisions to the service plan as necessary, to meet the participant's needs and to mitigate recurrence of the incident.

In cases where regulatory compliance or failure to effectively safeguard the participant is identified in the investigation, the CHC-MCO will conduct an on-site review of the incident which may include an audit of the MCO's Service Coordination Entity or Service Coordinator and/or direct service provider. In these cases, the CHC-MCO will audit agency procedures and make corrective recommendations resulting in a Statement of Findings. The provider must submit a Corrective Action Plan to the CHC-MCO within 30 days of the issuance of the Statement of Findings.

If OLTL determines that the CHC-MCO failed to effectively safeguard the participant or violated regulatory requirements, OLTL will conduct an on-site review to audit the CHC-MCO policy and procedures. OLTL will issue a Statement of Findings to the CHC-MCO, requiring a corrective action plan be submitted and completed within 30 days from the issuance of the Statement of Findings.

The time frames for conducting an investigation and completing an investigation.

The investigation of all critical incidents must be completed within thirty (30) days of receiving the incident report. If the time frame is not met, the details regarding the delay will be documented in EIM. The MCO will monitor 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.

The CHC-MCOs are responsible for providing oversight of Critical Incidents and events. OLTL staff from Bureau of Coordinated and Integrated Services (BCIS), review reports generated in EIM and reports generated by MCOs to track and trend critical incidents. BCIS staff work with the CHC-MCOs to assure that participant health and welfare is protected. Together, these bureaus discuss trends to identify systemic weaknesses or problems with individual and aggregate MCOs and providers.

The findings and quality improvement recommendations are shared with OLTL's Executive and Management staff at the monthly Quality Management Meetings (QM2) as well as the quarterly meetings with the CHC-MCOs.

Additional agencies have responsibilities for oversight on reports of abuse. The Department of Aging is responsible for administering protective services for the over 60 population; the Department of Human Services' Adult Protective Services Office handles protective services for the 18-60 disability population. The Department of Health has licensure requirements regarding reporting of incidents and conducts annual licensure of all Home Health and Home Care entities.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Title 55 PA. Code Chapter 52 prohibits the restraint of a participant. OLTL may impose sanctions for non-compliance.

OLTL is the unit of the State Medicaid Agency that is responsible for detecting the unauthorized use of restrictive interventions. OLTL approves the CHC-MCO Participant Handbook, which includes prohibition of the use of restraints, including chemical restraint, seclusion and other forms of restrictive interventions. At time of enrollment, participants receive a copy of the CHC-MCO Participant Handbook from the CHC-MCO and participants and their families are encouraged to call their Service Coordinator to report the unauthorized use of restraints. The Service Coordinator is responsible for reviewing this information with the participant annually. The CHC-MCO investigates and addresses unauthorized use of restrictive interventions.

OLTL is notified about unauthorized use of restraints through the CHC-MCOs in EIM. OLTL staff from the Bureau of Coordinated and Integrated Services will review reports generated in EIM weekly to track and trend critical incidents on restraints to identify systemic weaknesses or problems that will result in reports to the CHC-MCOs, corrective action plans and additional training to address the problem if indicated.

To assist in the detection of the unauthorized use of restraints, OLTL requires all CHC-MCOs to provide annual staff training as reviewed and approved by OLTL staff on detection and prevention of abuse and neglect including the use of restraints. All CHC-MCOs and their Service Coordinators are instructed to be vigilant for signs of unauthorized restraints, seclusion or other restrictive interventions through their routine monitoring and engagement with individuals.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. Use of Restrictive Interventions.** (*Select one*):

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Title 55 PA. Code Chapter 52.16 prohibits providers from using restraint as part of the provision of waiver services. Sanctions are available to the OLTL for non-compliance.

OLTL is the unit of the State Medicaid Agency that is responsible for detecting the unauthorized use of restrictive interventions. OLTL approves the CHC-MCO Participant Handbook, which includes prohibition of the use of restraints, including chemical restraint, seclusion and other forms of restrictive interventions. At time of enrollment, participants receive a copy of the CHC-MCO Participant Handbook from the CHC-MCO and participants and their families are encouraged to call their Service Coordinator to report the unauthorized use of restrictive interventions. The Service Coordinator is responsible for reviewing this information with the participant annually. The CHC-MCO investigates and addresses unauthorized use of restrictive interventions.

OLTL is notified about unauthorized use of restrictive interventions through the CHC-MCOs in EIM. OLTL staff from the Bureau of Coordinated and Integrated Services will review reports generated in EIM weekly to track and trend critical incidents on restrictive interventions to identify systemic weaknesses or problems that will result in reports to the CHC-MCOs, corrective action plans and additional training to address the problem if indicated.

To assist in the detection of the unauthorized use of restrictive interventions, OLTL requires all CHC-MCOs to provide annual staff training as reviewed and approved by OLTL staff on detection and prevention of abuse and neglect including the use of restrictive interventions. All Service Coordinators are instructed to be vigilant for signs of unauthorized restraints, seclusion or other restrictive interventions through their routine monitoring and engagement with individuals.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

OLTL is the unit within the State Medicaid Agency that is responsible for detecting the unauthorized use of seclusion. OLTL approves the CHC-MCO Participant Handbook, which includes prohibition of the use of restraints, including chemical restraint, seclusion and other forms of restrictive interventions. At time of enrollment, participants receive a copy of the CHC-MCO Participant Handbook from the CHC-MCO and participants and their families are encouraged to call their Service Coordinator to report the unauthorized use of seclusion. The Service Coordinator is responsible for reviewing this information with the participant annually. The CHC-MCO investigates and addresses unauthorized use of seclusion and other restrictive interventions.

OLTL is notified about unauthorized use of seclusion through the CHC-MCOs in EIM. OLTL staff from the Bureau of Coordinated and Integrated Services will review reports generated in EIM weekly, to track and trend critical incidents on restrictive interventions and seclusion to identify systemic weaknesses or problems that will result in reports to the CHC-MCOs, corrective action plans and additional training to address the problem if indicated.

To assist in the detection of the unauthorized use of seclusion, OLTL requires all CHC-MCOs to provide annual staff training as reviewed and approved by the OLTL staff on detection and prevention of abuse and neglect including the use of seclusion. All Service Coordinators are instructed to be vigilant for signs of unauthorized restraints, seclusion or other restrictive interventions through their routine monitoring and engagement with individuals.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

No. This Appendix is not applicable (*do not complete the remaining items*)

Yes. This Appendix applies (*complete the remaining items*)

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

CHC-MCO Network providers are the primary entity that has ongoing responsibility for monitoring participant medication regimens. As the professionals who prescribe the medications, they ensure that the medication regimen meets the participant's diagnosed condition, that none of the medications conflict and that the doses are prescribed correctly.

Medication monitoring also occurs through the development of the participant's PCSP and Service Coordinator review of the participant's services and during each face-to-face monitoring visit. As part of the annual reassessment, Service Coordinators collect complete information about the participant's medications, including what each medication is for, the frequency and dosage. Service Coordinators will have access to nurses and physicians employed by the CHC-MCOs to assist with questions about medications. Service Coordinators also review medication regimens for individuals during face-to-face monitoring visits and review EIM for reported medication errors. Incidents are reviewed by the CHC-MCOs which follow up with Service Coordinators to advise appropriate action.

Second-line monitoring is completed by Service Coordinators as outlined above and verified by the Department of Human Services, Bureau of Human Services Licensing (BHSL) annually for participants who live in licensed residential habilitation settings. Medications in licensed settings are governed under the following authority: 55 PA Code, Chapter 2600, §2600.181 through §2600.191. The CHC-MCOs monitor unlicensed Residential Habilitation provider's recorded and reportable medication errors to determine what medication administration and management problems are occurring for Residential Habilitation Service providers. Providers who have a high number of medication errors will be retrained.

When participants are receiving respite services in a nursing facility, the nursing facility regulations apply. The PA Department of Health (DOH) Bureau of Facility Licensure and Certification licenses and inspects Nursing Facilities, which are subject to the Nursing Home Regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1-483.75.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

OLTL uses the DHS Medication Administration Program to teach unlicensed staff to give medication to participants using a standard curriculum. Many of the provider agencies have nurses who become trainers and monitor medication through the course, while others provide oversight within the agency for medication administration and health issues. The course requires periodic reviews of staff performance to maintain certification. These include reviews of Medication Administration Records or logs for each staff member administering medications. The review of medication administration logs for errors in documentation includes matching the participant's prescribed medications on the log to those available to be given. Maintenance of certification requires review of four (4) Medication Administration Records and two (2) observations of passing medication and documentation. Providers are to use Medication Administration Records from different participants when completing the reviews so that each of the participants' medication regimens is reviewed across the year. The course also teaches staff to review medication when it is received from the pharmacy and compare it to the Medication Administration Records, thus providing a regular review of medications by provider staff. Part of the documentation and checks includes looking at medication allergies for the possibility of a contraindicated drug. CHC-MCOs may choose to train unlicensed staff to give medications in lieu of utilizing the DHS Medication Administration Program.

Providers administering medications are required to have a Medication Protocol in place that details the staff that have been trained and/or are licensed to administer medication, and ensures that providers have trained or licensed staff on duty when individuals need medication administered. The Medication Management Protocol will also detail how the provider monitors medication administration on a daily basis.

Despite the Department's extensive medications administration course, medication errors do sometimes occur. Providers are required to immediately report medication errors to the participant, the participant's designated party, when applicable, and the prescriber. Medication errors that require medical intervention, i.e. hospitalization or emergency room visits, must be reported to the CHC-MCO via EIM within 24 hours of occurrence or discovery as outlined in Appendix G-1-b. If the medication error is the result of a critical incident, such as neglect, or results in a critical incident, such as death, then it is not reported as a medication error, but rather as the higher-level critical incident, which is then subject to CHC-MCO investigation and review.

Documentation of medication errors and the prescriber's response must be kept in the participant's record. Providers are required to have a system in place to identify and document medication errors and the pattern of error. Providers must also document follow-up actions that have been taken to prevent future medication errors. Finally, providers are also required to educate participants of their right to question or refuse medication if the participant believes there may be a medication error. Documentation of this individual education must be kept in the participant's file.

If a participant experiences a suspected adverse reaction to a medication, the provider is required to immediately consult a physician or seek emergency medical treatment. Adverse reactions, the prescriber's response and any actions taken are documented in the participant's record.

The Department of Human Services, Bureau of Human Services Licensing (BHSL), monitors licensed Residential Habilitation providers' compliance with 55 PA Code, Chapter 2600, §2600.181 – §2600.191 on an annual basis, and is responsible for oversight and follow-up when licensed providers exhibit noncompliance.

Nursing Facilities are licensed and inspected by the PA DOH Health, Bureau of Facility Licensure and Certification and are subject to the Nursing Home regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1 – 483.75. DOH performs yearly surveys and medication management is part of the survey. Nursing facilities pharmacy management is governed under the following authority 28 pa code § 211.9 amended under section 803 of the Health Care Facilities Act (35 P. S. § 448.803); and section 2102(g) of The Administrative Code of 1929 (71 P. S. §532(g)).

The CHC-MCOs monitor unlicensed Residential Habilitation provider's recorded and reportable medication errors to determine what medication administration and management problems are occurring for Residential Habilitation Service providers. Providers who have a high number of medication errors will be retrained.

Appendix G: Participant Safeguards

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medication Administration by Licensed Residential Habilitation Providers:

Personal Care Home regulations, 55 PA Code, Chapter 2600, apply when participants receive Residential Habilitation Services in licensed settings. These regulations allow for the administration of medication by unlicensed staff when trained using the DHS-approved medications administration course. The current medications administration course requires the review of medication administration logs for errors in documentation including matching the person's prescribed medications on the log to those available to be given. Observations of medication passes are required on an annual basis. Clinical nursing staff is not required to take the administration course as this is part of their clinical scope of practice under the State Nursing Board. Self-administration guidelines also appear in the regulations, and setting up and monitoring self-administration programs are taught as part of the medication administration program. Personal Care Homes are licensed by the DHS, Bureau of Human Services Licensing, on an annual basis. These requirements do not apply to non-licensed providers.

Medication Administration by Unlicensed Residential Habilitation Providers:

Unlicensed Residential Habilitation providers are required to follow- OLTL's "Medication Management Policy for Unlicensed Providers Bulletin", which clarifies when a participant is expected to self-administer, receive assistance with medication administration, and the training required for provider staff to administer medication.

Self-Administration.

- (a) A provider shall assist individuals, as needed, with medication prescribed for the individual's self-administration. This assistance includes helping the individual to remember the schedule for taking the medication, storing the medication in a secure place and offering the individual the medication at the prescribed times.
- (b) If assistance includes helping the individual to remember the schedule for taking the medication, the individual shall be reminded of the prescribed schedule.
- (c) The individual's service plan shall identify if the individual is able to self-administer medications. An individual who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.
- (d) If the individual does not need assistance with medication, medication may be stored in an individual's room for self-administration. Medications stored in the individual's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.
- (e) To be considered capable to self-administer medications, an individual shall:
 - (1) Be able to recognize and distinguish his medication.
 - (2) Know how much medication is to be taken.
 - (3) Know when medication is to be taken.
- (f) The individual's record kept by the provider shall include a current list of prescriptions, Complementary and Alternative Medications (CAM) and Over the Counter (OTC) medications for each individual who is self-administering medication.

Medication Administration:

- (a) A provider may provide medication administration services for an individual who is assessed to need medication administration services and for an individual who chooses not to self-administer medications in accordance with an assessment done by a physician and documented on the individual's service plan.
- (b) Prescription medication that is not self-administered shall be administered by one of the following:
 - (1) A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.

- (2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the setting in which the medication is administered.
- (3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the setting the medication is administered.
- (4) A staff person who has completed the DHS-approved medication administration training for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Medication Administration Training

- (a) Pursuant to 55 Pa.Code § 52.14(t) (relating to ongoing responsibilities of providers), providers are required to participate in Department-mandated trainings. A provider who chooses to provide medication administration services for an individual who is assessed to need medication administration services in accordance with an assessment referenced above must participate in either the OLTL-approved medications administration course or have staff trained by the CHC-MCO.
- (b) The OLTL-approved medications administration course refers to the Department of Human Services Office of Developmental Program's training program. Information on this training program is found by calling 1-800-438-1958 or by going to: <https://medsadmin.tiu11.org/cms/>
- (c) A staff person who has successfully completed the OLTL-approved medications administration course that includes the passing of the OLTL-approved performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.
- (d) A staff person is permitted to administer insulin injections following successful completion of an OLTL-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of an OLTL-approved diabetes patient education program within the past 12 months.
- (e) A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Medication Administration by Nursing Facilities:

When participants are receiving respite services in a nursing facility, the nursing facility regulations apply. The PA Department of Health (DOH) Bureau of Facility Licensure and Certification licenses and inspects Nursing Facilities, which are subject to the Nursing Home Regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1-483.75.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

Providers are required to immediately report medication errors to the participant, the participant's designated party, when applicable, the MCO and the prescriber. Medication errors that require medical intervention, i.e. hospitalization or emergency room visits, must be reported to the CHC-MCO via EIM within 24 hours of occurrence or discovery as specified in OLTL Critical Incident Management Bulletin. EIM is accessible to providers, Service Coordinators and the CHC-MCOs.

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

Providers record medication errors which include: failure to administer a medication, administration of the wrong medication, administration of the wrong amount of medication, failure to administer a medication at the prescribed time, administration to the wrong person, and administration through the wrong route.

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

Medication errors that require medical intervention, i.e. hospitalization or emergency room visits, must be reported to the CHC-MCO via EIM within 24 hours of occurrence or discovery as specified in OLTL Critical Incident Management Bulletin.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

OLTL monitors performance of providers in the administration of medication to waiver participants both directly and indirectly. CHC-MCOs and OLTL will review incident reporting trends to identify and address any issues that arise with specific providers and/or participants. As described in section G-3-b-i, direct monitoring occurs through annual DHS licensing reviews of licensed Residential Habilitation providers and the CHC-MCOs monitoring reviews of unlicensed Residential Habilitation providers. In addition, direct monitoring occurs as part of the Service Coordinator's face-to-face monitoring visits with participants. If the SC identifies issues with medication management during their monitoring visits, the PCSP will be reviewed to determine what additional supports may be necessary.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

HW-1: Number and percent of unexplained deaths where appropriate follow-up or steps were taken. Numerator: Unexplained deaths for which review resulted in findings where appropriate follow-up or steps were taken. Denominator: Total number of unexplained deaths.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligations and validated by OLTL

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 = <input type="text"/>
Other Specify: <input type="text" value="CHC-MCO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text" value="Bi-annually"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>

Performance Measure:

HW 9: Number and percent of substantiated cases of abuse, neglect and exploitation where potential issues related to health and welfare were addressed. Numerator: Number of substantiated cases of abuse, neglect and exploitation where potential issues related to health and welfare were addressed. **Denominator:** Total number of substantiated cases of abuse, neglect and exploitation

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligations and validated by OLTL

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

		<input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

HW-4: Number and % of CHC participants informed of reporting process for abuse, neglect & exploitation in initial & annual reviews. Num: # of newly eligible CHC participants & current participants due for an annual reassessment who were informed of the reporting process. Denom: Total # of newly eligible CHC participants & current participants due for an annual reassessment within a time period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Operational reports submitted by CHC-MCOs per contractual obligation and validated by OLTL.

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 = <div>95% +/-5%</div>
Other Specify: <div>CHC-MCO; IEB</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify:	

	Bi-annually	
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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: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

HW-6: Number and percent of critical incidents reported within the prescribed time frame. Numerator: Number of critical incidents reported within the prescribed time frame. Denominator: Number of critical incidents reported.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligations and validated by OLTL

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: CHC-MCO	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: Bi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: CHC-MCO	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

HW-5: Number and percent of incidents for CHC waiver participants each month with more than 3 reported incidents within the past 12 months where results of trend

analysis were addressed by the CHC-MCO. Numerator: Total number of incidents for CHC waiver participants each month with more than 3 reported incidents within the past 12 months where results of Continued in Main Module Optional

Data Source (Select one):

Other

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligations and validated by OLTL

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 = <input type="text"/>
Other Specify: <input type="text" value="CHC-MCO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text" value="Bi-annually"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

HW-7: Number and percent of critical incidents investigated within the prescribed time frame. Numerator: Number of critical incidents investigated within the prescribed time frame. Denominator: Number of critical incidents reported.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligations and validated by OLTL

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify:	Annually	Stratified Describe Group:

CHC-MCO		
	Continuously and Ongoing	Other Specify:
	Other Specify: Bi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: CHC-MCO	Annually
	Continuously and Ongoing
	Other Specify:

- c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-8: Number and percent incidents where either restraints or seclusion were used and appropriate follow up occurred by the CHC-MCO. Numerator: Number of incidents where either restraints or seclusion were used and appropriate follow up occurred by the CHC-MCO. Denominator: Total number of incidents where either restraints or seclusion were used.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Operations reports submitted by CHC-MCOs per contractual obligations and validated by OLTL

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

HW-10: Number and percent of participants who had an ambulatory or preventive care visit during the measurement year. Numerator: Number of participants who had one or more ambulatory or preventive care visits during the measurement year and have Medicaid only or Medicaid and Medicare benefits with the same MCO.

Denominator: Total CHC participants who *Continued in Main Module Optional**

Data Source (Select one):

Other

If 'Other' is selected, specify:

HEDIS data and reports submitted by CHC-MCOs per contractual obligations

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):
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State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="CHC-MCOs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

- 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.

CHC-MCOs and their Network Providers and Subcontractors must report critical events or incidents via the Department's Enterprise Incident Management System (EIM). CHC-MCOs must also investigate critical events or incidents reported by Network Providers and Subcontractors and report the outcomes of these investigations in EIM and via monthly reports to OLTL. Statistical reports on reported critical incidents and complaints are generated from the state's Enterprise Incident Management (EIM) system. Reports are reviewed monthly and quarterly by the Bureau of Coordinated and Integrated Services for patterns in the types of incidents documented. The Bureau will also identify patterns and concerns regarding how the incidents are processed, investigated, and remediated. Please see Appendix H for more information.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States 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.

CHC-MCOs are responsible to report on incidents according to the policies in the contract. 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.) the Bureau of Coordinated and Integrated Services (BCIS) will immediately direct the CHC-MCO to complete an investigation, address the critical incident and otherwise meet OLTL incident standards. If immediate action is required to protect the Health and Welfare of the individual, the CHC-MCO shall take such action as appropriate. BCIS may be required to investigate and/or take action if an employee of the CHC-MCO is identified as a source of the incident. When a pattern of not reporting or otherwise following OLTL's incident management protocols is identified, BCIS will make a referral to the appropriate Core Team for review of the CHC-MCOs incident policies and procedures. As issues are discovered, Corrective Action Plans (CAPs) may be required of the CHC-MCOs. Individual incidents of a severe nature are investigated and reviewed in accordance with Appendix G. BCIS reviews CHC-MCO reports for patterns involving trends, providers, geographic areas, etc. If specific provider(s) are involved in a pattern of frequent incidents, a referral is made to Core Team staff for a targeted review and possible Corrective Action Plan (CAP).

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and

- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

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) is responsible for the statewide administration of Pennsylvania's long-term services and support program, the Community HealthChoices (CHC). OLTL's quality strategy will be to meet federal and state requirements 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.

OLTL responsibilities include assessing and improving the quality of services received by participants in various long-term living settings and monitoring fiscal and regulatory compliance. Key bureaus focused on the operations of the Community HealthChoices program include:

- Bureau of Fee for Service Programs (BFFSP)
- Bureau of Quality Assurance and Program Analytics (BQAPA)
- Bureau of Coordinated and Integrated Services (BCIS)
- Bureau of Policy Development and Communications Management (BPDCM)
- Bureau of Finance (BOF)

All Bureaus play a role in ensuring CHC-MCOs and other related contractors comply with contractual obligations, and federal and state regulations. Data analysis is utilized to measure effectiveness of program design and operations, which will help in identifying strategies for continuous quality improvements in the delivery of service. Each of the contracts will have a contract manager to ensure vendor is meeting all contractual obligations, which includes IEB, independent assessment, and the external quality review organization (EQR).

As part of stakeholder engagement, OLTL includes the Long-Term Services and Supports (LTSS) and Managed Long-Term Services and Supports (MLTSS) subcommittees of the Medical Assistance Advisory Committee to request feedback on quality management activities.

BQAPA'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. All bureaus will work collectively to review data that has been compiled from the CHC-MCOs, on-site OLTL monitoring and data analysis conducted by the External Quality Review Organization, (EQRO). These data sources are utilized to identify issues, trends and quality oversight, and is used in waiver reporting. All CHC-MCOs are expected to adhere to contract requirements, and follow all OLTL bulletins, operational memo, and notices and meet expected time frames.

OLTL will implement a process for trending discovery and remediation information received from various points in the OLTL system as well as from the contracted EQR and the CHC-MCOs. Reports will be created by BQAPA to trend various aspects of quality including administrative authority, health and welfare, financial accountability, service plan development and implementation, level of care review, and provider qualifications. More detailed information, including performance measures, is available under each of the appendices that pertain to the six waiver assurances (see individual Appendix A, B, C, D, G and I, respectively).

CHC-MCOs are also required to annually administer the HCBS CAHPS Survey to gather feedback on HCBS participants' experience receiving long-term services and supports. CHC-MCOs will administer the most current version of the instruments and report survey results to DHS/OLTL as required under the CHC agreement. This includes using the Supplemental Employment Module specifically designed to be used alongside the HCBS CAHPS Survey tool as well as Pennsylvania specific questions designated by OLTL that relate to service plan, transportation, housing, and preventative health care. In 2018, each individual CHC-MCO will survey a random sample that generates a targeted number of complete surveys. Starting in 2019, the CHC-MCO will select a statistically valid random sample based on a 95% Confidence Level, \pm 5% Confidence Interval, and a 50% Distribution, proportioned by region.

The overall results of the Pennsylvania OLTL HCBS CAHPS Survey will be provided to DHS/OLTL. MCOs will report on the aggregate information about experience of care related to the services and supports provided to the surveyed population. The current level and trend over time in the HCBS CAHPS composite measure scores will be reviewed by CHC-MCOs together with the component survey items that indicate actionable aspects of the experience of care. Opportunities for improving the experience of care will be identified and implemented. CHC-MCOs will submit a narrative report to DHS/OLTL with the results of each HCBS CAHPS Survey data collection. The narrative report will include a summary of what the plan learned about participant experience of

care and aspects of participant health and welfare, potential areas of concern or opportunities for improvement, and steps to further investigate and/or address quality improvement opportunities.

BQAPA will convene monthly internal Quality Monthly Meetings (QM2) as well implement a Quarterly Quality Review Meeting (QCRM) to ensure that there are devoted meetings with each individual MCO to discuss key quality indicators, best practices and areas for improvements. The basis of these meetings will be an open, creative, collaborative dialogue between all OLTL bureaus and the CHC-MCOs with an emphasis on quality outcomes. The QCRM is an opportunity to review:

- CHC-MCO performance against stated goals;
- Investigate causes of missed goals and targets;
- Implement corrective action steps for plans that missed targets;
- Establish new targets;
- Identify opportunities for program improvements; and
- Develop special studies for populations being served under CHC.

OLTL has designed an approach in oversight and monitoring of the CHC program. This includes a comprehensive statewide Medical Assistance Quality Strategy for Pennsylvania, which outlines a number of key components on how OLTL will ensure quality assurance that will help identify system improvements for CHC to include: readiness review, early implementation and ongoing monitoring. CHC-MCOs will be required to support all key quality components, as follows but not limited to:

- Contractual Monitoring and Compliance, which will include early program launch and steady state monitoring. Using a two-prong approach will allow the state to coordinate its approach in each cycle impacting the CHC program implementation. This will also help ensure CHC-MCOs are ready to provide services, identify unanticipated implementation challenges and address them in real time, and conduct annual monitoring of plans.
- Complaints, Grievances and Appeals (see Appendix F under this application for more detailed information)
- Utilize the statewide EIM system for Critical Incidents
- Performance measures using indicators established by the Center for Medicare and Medicaid Service (CMS) and various national organizations:
 - o Healthcare Effectiveness Data and Information Set (HEDIS)
 - o CMS Medicaid Adult Core Measures
 - o CMS Nursing Facility Measures
 - o Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
 - o Medicare Measures for Dual-Eligible Special Needs Plans (D-SNPs)
- PA-specific state measures which will help gauge performance, monitor compliance with state and federal regulations and guidelines, and ensure CHC participants are receiving quality services in a timely manner.
- EQRO will conduct independent series of external quality review activities involving MCOs providing LTSS, physical health services, and behavioral health services, as well as Medicare providers, and assist the state in ensuring coordination of care.
- Independent evaluation conducted by the Health Policy Institute, Medicaid Research Center at the University of Pittsburgh.

BCIS will be responsible for CHC-MCO annual monitoring and remediation activities. This includes a review of Corrective Action Plans (CAPs) submitted by CHC-MCOs to correct non-compliance issues and will be reviewed and approved by BCIS. BCIS will work with CHC-MCOs to establish realistic timeframes for the successful completion of activities listed in the CAP. CAPs are closed only upon approved completion.

In order to prioritize quality management issues, BQAPA has assigned each of the five waiver assurances to a quality management (QM) liaison to review various quality reports through tracking and trending and determine possible causes of aberrant data or compliance issues. Quality data is gathered for performance measures from numerous sources, including OLTL discovery and remediation activities, on-site monitoring by the OLTL, as well as internal OLTL activities/reporting. This information is aggregated for tracking and trending. The QM liaison makes initial recommendations and prioritizes issues for problem-solving or corrective measures. The QM liaison reviews and responds to aggregated, analyzed discovery and remediation information collected on each of the assurances, and makes initial recommendations and prioritizes issues for problem-solving or corrective measures. In addition to trending and analyzing, this structure allows BQAPA to review for possible internal OLTL systemic changes and to identify possible program training or technical assistance needs.

BQAPA internally reviews the assessments made by the QM liaison. For those issues that are considered critical by the QM liaison, an expedited process of review is implemented by working closely with other OLTL bureaus. The QMU summarizes the list of priorities and recommendations in a monthly report to present at the monthly QM2 meetings, which are attended by key personnel from all OLTL bureaus. The comments from the quality meetings are considered and included in a revised report for discussion with the MCOs during weekly update meetings. OLTL Bureau Directors will collectively submit final recommendations as to any action needed for system improvements to the Deputy Secretary of OLTL. The implemented system improvements return to the quality cycle through monitoring and remediation.

The results of review findings and system improvements are communicated to agencies upon request. Waiver providers are informed through policy bulletins and OLTL trainings. Participants, families, other interested parties and the public are informed through monthly Managed Long-Term Services and Supports Subcommittee (MLTSS SubMACC) meetings, and in the Managed Care Organizations (MCO) participant handbook.

ii. System Improvement Activities

Responsible Party (<i>check each that applies</i>):	Frequency of Monitoring and Analysis (<i>check each that applies</i>):
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.

BQAPA assists the OLTL in developing quality management improvement strategies for needed system design changes. BQAPA 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 the contracted EQRO or provided by the CHC-MCO's and given to BQAPA for analysis. The analyses are reviewed in the same manner as other reports, creating a cycle of continuous quality improvement.

CHC will be implemented starting in January 2018. OLTL plans to meet regularly with CHC-MCOs to discuss operations issues and to apprise the CHC-MCOs of administrative changes and updates that may have an impact on service delivery. In addition, our intent will be to mirror the existing HealthChoices program and implement a Quarterly Quality Review Meeting (QQRN) to ensure that there are devoted meetings with each individual MCO – to discuss key quality indicators, best practices and areas for improvements. The basis of these meetings will be an open, creative, collaborative dialogue with OLTL and the CHC-MCOs with an emphasis on quality outcomes.

BCIS will also monitor CHC-MCO agreements, review and approve subcontracts, identify areas of non-compliance, approve corrective action plans and recommend sanctions and penalties where appropriate. It will also monitor the CHC-MCOs to ensure the provision of a fair enrollment process into the provider network.

- 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 during the monthly quality meetings. The results of aggregated information pertaining to the delivery of services including all corrective action plan activities of the CHC-MCOs, CHC-MCOs billing information, analysis of CHC-MCOs adherence to performance measures established, etc. will be reviewed and discussed to evaluate the effectiveness of program success. Any needed alterations to the QIS will be made on an ongoing basis.

Performance Measure data for the Administrative Authority, Level of Care, and Financial Accountability Assurances are captured on reports compiled by OLTL contracted vendors. The reports are submitted quarterly and reviewed by OLTL subject matter experts (SME). Contracted vendors are required to account for the data scores as well as remediation efforts.

Performance Measure data for the Service Plans and Health and Welfare Assurances are reported to OLTL on a monthly basis by the Managed Care Organizations (MCO). In addition to providing data scores for the performance measures, MCOs are required to provide information regarding remediation activities. OLTL SMEs review the reports for accuracy as well as analyze the data, review quality improvement projects, examine corrective action plans and assess remediation efforts. As needed OLTL SMEs provide direction to the MCOs.

Performance Measure data for the Qualified Providers Assurance is captured through internal reports and is monitored by OLTL staff.

The OLTL Division of Quality Assurance meets formally with the SMEs for all EBR performance measures every six months to review the data and remediation efforts. Trends are identified and strategies established to improve the quality of waiver services. Informal discussions are also held throughout the year to discuss data trends, quality improvement projects, corrective action plans and remediation efforts.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

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).

Waiver services are furnished through the managed care entities, and therefore, the §1915(b) waiver financial accountability requirements apply.

With respect to the integrity of the payments to the managed care entities, the CHC-MCO agreements provide, in part, the following:

“The CHC-MCO shall cause, and bear the costs of, an annual agreement audit to be performed by an independent, licensed Certified Public Accountant. The agreement audit shall be completed using guidelines provided by the Commonwealth. Such audit shall be made in accordance with generally accepted government auditing standards. The contract audit shall be digitally submitted to OLTL, Bureau of Finance via the E-FRM system no later than June 30 after the contract year is ended.... The Commonwealth reserves the right for federal and state agencies or their authorized representatives to perform additional financial or performance audits of the CHC-MCO, its subcontractors or Providers.”

The CHC-MCO agreements also contain a provision allowing the Commonwealth to conduct financial, compliance, and performance audits, in addition to audits of automated data processing operations to verify that systems are in place to ensure that financial and programmatic data being submitted to the Commonwealth is properly safeguarded, accurate, timely, complete, reliable, and in accordance with the contract terms and conditions.

Using monthly encounter data, OLTL will ensure payments to the CHC-MCOs are for eligible persons properly enrolled in the waiver.

Electronic Visit Verification (EVV)

The Department of Human Services will be using an Open Vendor Model to implement and comply with EVV system requirements in accordance with section 12006 of the 21st Century CURES Act. Since Pennsylvania has chosen to utilize an open vendor model, visit capture technology varies across EVV vendors. Generally, the methods used to capture visits include mobile phone applications, telephonic entry via a landline telephone, and fixed verification devices. The specific waiver services included in the EVV system are Personal Assistance Services, Participant-Directed Community Supports and Respite (unlicensed facility).

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:

FA-1: Number and percent of capitation payments reviewed by DHS or an independent auditor that are in accordance with the methodology approved by CMS. Numerator:

Total number of capitation payments found in compliance with the methodology approved by CMS. Denominator: Total number of capitation payments reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Department of Human Services MMIS

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 = <input type="text"/>
Other Specify: <input type="text" value="CHC-MCOs CPA firm"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text" value="Bi-annually"/>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <div>CHC-MCOs CPA firm</div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <div></div>

- b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

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

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

Performance Measure:

FA-2: Capitation payments to the CHC-MCOs that are made in accordance with CMS approved actuarially sound rate methodology. Numerator: Capitation payments made to the CHC MCOs at the approved rates through the CMS certified MMIS. Denominator: Total number of capitation payments using the appropriate rate through the CMS certified MMIS.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Department of Human Services Client Information System, MMIS

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

<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <input type="text"/>
<i>Other Specify:</i> <input type="text"/>	<i>Annually</i>	<i>Stratified Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <input type="text"/>
	<i>Other Specify:</i> <input type="text"/>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i> <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other Specify:</i>

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The CHC MCOs are also required to submit financial reports to DHS on a quarterly basis and annual basis to substantiate continued MCO solvency.
Based on the 1915(b) concurrent waiver application, please refer to the 1915(b) application for information regarding further performance measures on the integrity of data and other strategies by the State to discover and identify problems within the waiver program.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States 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.

Based on the 1915(b) concurrent waiver application, please refer to the 1915(b) application for information regarding remediation and fixing individual problems.

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: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

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).

Under CHC, the method of determining the capitation rate is subject to the 1915(b) requirements and criteria. The Commonwealth has contracted with an actuarial firm to develop the actuarially sound capitation payment rates on an annual basis.

There was a 1% annual unit cost trend was included as an estimate of potential future fee schedule unit cost growth during the prospective time period including inflationary growth in services paid at cost such as Assistive Technology, Specialized Medical Equipment & Supplies, etc. The 1% factor was informed by BLS employment cost index trends and actual historical fee schedule rate increases that OLTL has made.

- 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:

The waiver services are billed through a managed care entity. The CHC-MCO billings to the state are made in accordance with the provisions of the §1915(b) waiver and provider billings to the managed care entity are made in the terms of the provider's contract with the managed care entity.

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:*

The waiver services are billed through a managed care entity. The CHC-MCO billings to the state are made in accordance with the provisions of the §1915(b) waiver and provider billings to the managed care entity are made in the terms of the provider's contract with the managed care entity.

- 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:

The Department will compute Capitation payments using per diem rates. Using wire transfer or electronic funds transfer, the Department will make a monthly payment to the CHC-MCO by the 15th day of the month for each participant enrolled in the CHC-MCO. The Department will not make a Capitation payment for a Participant Month if the Department notifies the CHC-MCO before the first of the month that the individual's MA eligibility or CHC-MCO Enrollment ended prior to the first of the month. The Department will recover Capitation payments for participants who were later determined to be ineligible for managed care or for payments made for deceased participants after their date of death.

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.

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.

Providers will not be paid by the State for services not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

No. *The state does not make supplemental or enhanced payments for waiver services.*

Yes. *The state makes supplemental or enhanced payments for waiver services.*

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-

Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

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.

Capitation payments made to CHC-MCOs may be reduced or returned, in part, to the State. The CHC-MCO Agreements contain provisions for a Risk Corridor, High Risk Pool, a Medical Loss Ratio and a Member Enrollment Mix Adjustment. These risk mechanisms are retrospective or prospective risk adjustments and/or budget neutral.

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. Service Coordination agencies may provide those services outlined in Appendix D-1-b and D-2-b through an OHCDs only during the 180-day continuity of care period for each implementation phase. Such requests are reviewed and approved by OLTL and the CHC-MCO prior to any service provided through the OHCDs arrangement. This arrangement is expected to end no later than June 30, 2020.
- b. Providers who are not affiliated with an OHCDs must enroll in the Pennsylvania Medical Assistance program and seek inclusion in the CHC-MCO's provider network.
- c. As described in Appendix D-1-b and D-2-b, individuals are fully informed of their right to choose from any qualified provider that is part of the CHC-MCO's provider network, and are not required to utilize the OHCDs arrangement. As noted above, providers who are not affiliated with an OHCDs must enroll in the Pennsylvania Medical Assistance program and seek inclusion in the CHC-MCO's provider network.
- d. Through provider/SC oversight and monitoring, as well as through information garnered through service plan and encounter data, the CHC-MCOs monitor services provided through an OHCDs to ensure that the OHCDs has contracted only with providers meeting established 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 provider and SC monitoring processes performed by the CHC-MCOs. 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.

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.

This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

In accordance with 42 CFR 441.310(a)(2), the Commonwealth does not pay the cost of room and board and did not include costs associated with room and board in the capitation rate development process. The CHC-MCOs will negotiate rates with each residential service provider based upon the assessed medical and functional needs and circumstances of each participant receiving services in a residential setting. These rates specifically exclude room and board.

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

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	43229.16	8138.00	51367.16	61521.00	2206.00	63727.00	12359.84
2	50130.87	10259.00	60389.87	70877.00	4805.00	75682.00	15292.13
3	55742.33	10843.00	66585.33	72856.00	5079.00	77935.00	11349.67
4	58195.00	11460.00	69655.00	74891.00	5368.00	80259.00	10604.00
5	60754.93	12113.00	72867.93	76982.00	5673.00	82655.00	9787.07

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (1 of 9)**

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	107404		107404
Year 2	116996		116996
Year 3	128146		128146
Year 4	140352		140352
Year 5	153698		153698

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.

The average length of stay for the CHC waiver, as outlined in Appendix J-2, was projected utilizing historical CY 2019 experience. This experience reflects either historical Medicaid waiver enrollee durational patterns for individuals enrolled in one of OLTL's historic five waivers (Aging, Attendant Care, CommCare, Independence, and OBRA) for zones not yet implemented in CHC for CY 2019 (Lehigh/Capital, Northeast, Northwest) or from CHC managed care program experience for the two implemented zones (Southwest and Southeast). The individuals enrolled in one of OLTL's historic waivers moved into the CHC waiver upon CHC implementation within each geographic zone (effective January 1, 2018 in the Southwest Zone, effective January 1, 2019 in the Southeast Zone and effective January 1, 2020 in the Lehigh/Capital, Northeast, and Northwest zones). All CHC zones were implemented on or before January 1, 2020 (i.e., the beginning of Waiver Year 1).

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 and methodology for these estimates is as follows:

Appendix J-2 Factor D projections were derived from actual Medicaid waiver user, service utilization, and cost data from January 2019–December 2019, and was adjusted based on more recent experience in CY 2020 impacted by the Coronavirus Disease 2019 (COVID-19) pandemic. The data was limited to participants within the five historic OLTL waivers (Aging, Attendant Care, CommCare, Independence, and OBRA) for Lehigh/Capital, Northeast, and Northwest, and available CHC program experience for the Southwest and Southeast zones. The data was analyzed at a statewide level given all zones were implemented on or before January 1, 2020 (i.e., the beginning of Waiver Year 1).

For Waiver Years 2–5, unit costs were trended forward for all services using a 1.0% annual inflation factor. Unit per user values were trended at 1.4% annually for all services except personal assistance, where units were trended at 3.5% annually. These factors were based on a review of historical utilization and cost increases within the Commonwealth and reflect consideration for CHC being fully transitioned into managed care statewide by CY 2020.

Based on review of preliminary CY 2020 results, Adult Daily Living services experienced depressed utilization from waiver participants in CY 2020 (Waiver Year 1) as a result of the COVID-19 pandemic, and that is anticipated to continue into Waiver Year 2 as Adult Daily Living service locations begin to re-open during CY 2021. Adult Daily Living service utilization is anticipated to better align with pre-pandemic experience in CY 2022–CY 2024 (i.e., Waiver Years 3–5).

Effective January 1, 2022, OLTL will implement a fee increase for personal assistance services, resulting in an average cost per unit increase of 6.4%. This change is reflected in CY 2022–CY 2024 (i.e., Waiver Years 3–5), and is in addition to the Factor D inflation factor assumptions described above.

- 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:*

Factor D' was derived from actual January 2019–December 2019 Medicaid acute medical and behavioral health service costs for participants within the five historic OLTL waivers (Aging, Attendant Care, CommCare, Independence, and OBRA) for Lehigh/Capital, Northeast, and Northwest, and available CHC managed care program experience for the Southwest and Southeast zones. Factor D' was calculated by dividing the actual costs for these services by the count of unique waiver recipients. The costs of prescribed drugs that will be furnished to Medicare/Medicaid dual eligibles under the provisions of Part D have been excluded. Per capita costs were trended forward using a 5.7% annual inflation factor. This factor was based on a review of historical cost increases for similar services within the Commonwealth.

- 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:*

Factor G was derived from a review of January 2019–December 2019 Medicaid nursing facility service utilization and cost data for individuals whom OLTL determined represented a comparable peer group to CHC waiver participants. For Waiver Years 2–5, costs were trended forward using a 2.8% annual inflation factor. This factor was based on a review of historical cost increases for nursing facility services.

- 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:*

For the individuals whom OLTL determined represented a comparable peer group to CHC waiver participants (as mentioned in Factor G), Factor G' was derived by analyzing these individuals' associated non-nursing facility Medicaid service utilization and costs during the time period from January 2019–December 2019. The costs of prescribed drugs that will be furnished to Medicare/Medicaid dual eligibles under the provisions of Part D have been excluded. These costs were trended forward using a 5.7% inflation rate. This factor was based on a review of historical cost increases for similar services within the Commonwealth.

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Adult Daily Living	
Employment Skills Development	
Job Coaching	
Personal Assistance Services	
Residential Habilitation	
Respite	
Structured Day Habilitation Services	
Counseling Services	
Home Health Aide Services	
Nursing Services	
Occupational Therapy Services	
Physical Therapy Services	
Specialized Medical Equipment and Supplies	
Speech and Language Therapy Services	
Assistive Technology	
Behavior Therapy	
Benefits Counseling	
Career Assessment	
Cognitive Rehabilitation Therapy Services	
Community Integration	
Community Transition Services	
Home Adaptations	
Home Delivered Meals	
Job Finding	
Non-Medical Transportation	
Nutritional Consultation	
Participant-Directed Community Supports	
Participant-Directed Goods and Services	
Personal Emergency Response System (PERS)	
Pest Eradication	
TeleCare	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Daily Living Total:							57176487.90
Adult Daily Living Services		Day, Half Day	5193	147.00	74.90	57176487.90	
Employment Skills Development Total:							2689092.64
Employment Skills Development		15 Min	136	2938.00	6.73	2689092.64	
Job Coaching Total:							807087.60
Job Coaching		15 Min	66	1145.00	10.68	807087.60	
Personal Assistance Services Total:							4184481187.70
Personal Assistance Services		15 min	104453	8690.00	4.61	4184481187.70	
Residential Habilitation Total:							58209891.52
Residential Habilitation Services		Per Diem, Hour	583	1226.00	81.44	58209891.52	
Respite Total:							3454291.20
Respite Services		15 Min	1114	320.00	9.69	3454291.20	
Structured Day Habilitation Services Total:							22927449.60
Structured Day Habilitation Services		Hour	704	999.00	32.60	22927449.60	
Counseling Services Total:							78820.54
Counseling Services		15 Min	106	61.00	12.19	78820.54	
Home Health Aide Services Total:							33860.48
Home Health Aide Services		15 Min	4	1528.00	5.54	33860.48	
Nursing Services Total:							158509776.00
Nursing Services		15 Min	3725	3594.00	11.84	158509776.00	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							4642984893.44 4642984893.44 107404 43229.16 43229.16 338

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy Services Total:							1362873.28
Occupational Therapy Services		15 Min	664	97.00	21.16	1362873.28	
Physical Therapy Services Total:							1262493.00
Physical Therapy Services		15 Min	621	100.00	20.33	1262493.00	
Specialized Medical Equipment and Supplies Total:							5745475.44
Specialized Medical Equipment and Supplies		Per Purchase	9377	6.00	102.12	5745475.44	
Speech and Language Therapy Services Total:							878527.62
Speech and Language Therapy Services		15 Min	243	163.00	22.18	878527.62	
Assistive Technology Total:							82009.80
Assistive Technology		Per Purchase	180	3.00	151.87	82009.80	
Behavior Therapy Total:							3111474.96
Behavior Therapy		15 Min	418	348.00	21.39	3111474.96	
Benefits Counseling Total:							651.60
Benefits Counseling		15 Min	2	30.00	10.86	651.60	
Career Assessment Total:							6538.05
Career Assessment		15 Min	3	167.00	13.05	6538.05	
Cognitive Rehabilitation Therapy Services Total:							12562137.72
Cognitive Rehabilitation Therapy Services		15 Min	971	891.00	14.52	12562137.72	
Community							632151.87
GRAND TOTAL:							4642984893.44
Total: Services included in capitation:							4642984893.44
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							107404
Factor D (Divide total by number of participants):							43229.16
Services included in capitation:							43229.16
Services not included in capitation:							
Average Length of Stay on the Waiver:							338

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integration Total:							
Community Integration		15 Min	89	1043.00	6.81	632151.87	
Community Transition Services Total:							250848.90
Community Transition Services		Per Purchase	111	2.00	1129.95	250848.90	
Home Adaptations Total:							44005380.51
Home Adaptations		Per Adaptation	7357	3.00	1993.81	44005380.51	
Home Delivered Meals Total:							27289468.80
Home Delivered Meals		Per Purchase	19360	246.00	5.73	27289468.80	
Job Finding Total:							21889.14
Job Finding		15 Min	13	133.00	12.66	21889.14	
Non-Medical Transportation Total:							30797331.84
Non-Medical Transportation		Per Trip	11174	99.00	27.84	30797331.84	
Nutritional Consultation Total:							110.16
Nutritional Consultation		15 Min	1	8.00	13.77	110.16	
Participant-Directed Community Supports Total:							1979652.07
Participant-Directed Community Supports		Per Purchase	37	11.00	4864.01	1979652.07	
Participant-Directed Goods and Services Total:							61436.70
Participant-Directed Goods and Services		Per Purchase	9	5.00	1365.26	61436.70	
Personal Emergency Response System (PERS) Total:							21637414.70
GRAND TOTAL:							4642984893.44
Total: Services included in capitation:							4642984893.44
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							107404
Factor D (Divide total by number of participants):							43229.16
Services included in capitation:							43229.16
Services not included in capitation:							
Average Length of Stay on the Waiver:							338

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System (PERS)		Month	60899	10.00	35.53	21637414.70	
Pest Eradication Total:							273000.00
Pest Eradication		Per Purchase	182	1.00	1500.00	273000.00	
TeleCare Total:							393051.15
TeleCare		OneTime,Mnthly,Purcha	811	15.00	32.31	393051.15	
Vehicle Modifications Total:							2263030.95
Vehicle Modifications		Per Adaptation	115	1.00	19678.53	2263030.95	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							4642984893.44 4642984893.44 107404 43229.16 43229.16 338

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Daily Living Total:							33815782.00
Adult Daily Living Services		Day, Half Day	4655	110.00	66.04	33815782.00	
Employment Skills Development Total:							1347226.52
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							5865110949.15 5865110949.15 116996 50130.87 50130.87 337

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Skills Development		15 Min	62	3539.00	6.14	1347226.52	
Job Coaching Total:							146700.84
Job Coaching		15 Min	33	412.00	10.79	146700.84	
Personal Assistance Services Total:							5489536373.44
Personal Assistance Services		15 min	113779	10136.00	4.76	5489536373.44	
Residential Habilitation Total:							49416774.66
Residential Habilitation Services		Per Diem, Hour	549	506.00	177.89	49416774.66	
Respite Total:							2196560.76
Respite Services		15 Min	604	723.00	5.03	2196560.76	
Structured Day Habilitation Services Total:							20355634.80
Structured Day Habilitation Services		Hour	681	874.00	34.20	20355634.80	
Counseling Services Total:							76185.20
Counseling Services		15 Min	56	115.00	11.83	76185.20	
Home Health Aide Services Total:							1830075.39
Home Health Aide Services		15 Min	279	417.00	15.73	1830075.39	
Nursing Services Total:							61070845.06
Nursing Services		15 Min	1667	3194.00	11.47	61070845.06	
Occupational Therapy Services Total:							431020.80
Occupational Therapy Services		15 Min	105	192.00	21.38	431020.80	
Physical Therapy Services Total:							421617.60
Physical						421617.60	
GRAND TOTAL:							5865110949.15
Total: Services included in capitation:							5865110949.15
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							116996
Factor D (Divide total by number of participants):							50130.87
Services included in capitation:							50130.87
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapy Services		15 Min	228	92.00	20.10		
Specialized Medical Equipment and Supplies Total:							3300729.60
Specialized Medical Equipment and Supplies		Per Purchase	7872	35.00	11.98	3300729.60	
Speech and Language Therapy Services Total:							249898.32
Speech and Language Therapy Services		15 Min	63	179.00	22.16	249898.32	
Assistive Technology Total:							22825.46
Assistive Technology		15 Min	38	7.00	85.81	22825.46	
Behavior Therapy Total:							2931026.07
Behavior Therapy		15 Min	353	399.00	20.81	2931026.07	
Benefits Counseling Total:							155.26
Benefits Counseling		15 Min	1	14.00	11.09	155.26	
Career Assessment Total:							426.36
Career Assessment		15 Min	1	33.00	12.92	426.36	
Cognitive Rehabilitation Therapy Services Total:							2310406.74
Cognitive Rehabilitation Therapy Services		15 Min	213	758.00	14.31	2310406.74	
Community Integration Total:							288543.15
Community Integration		15 Min	63	695.00	6.59	288543.15	
Community Transition Services Total:							1577081.76
Community Transition Services		Per Purchase	654	2.00	1205.72	1577081.76	
GRAND TOTAL:							5865110949.15
Total: Services included in capitation:							5865110949.15
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							116996
Factor D (Divide total by number of participants):							50130.87
Services included in capitation:							50130.87
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Adaptations Total:							39825638.00
Home Adaptations		Per Adaptation	4898	4.00	2032.75	39825638.00	
Home Delivered Meals Total:							62438955.60
Home Delivered Meals		Per Purchase	33810	274.00	6.74	62438955.60	
Job Finding Total:							11036.00
Job Finding		15 Min	10	89.00	12.40	11036.00	
Non-Medical Transportation Total:							59575941.36
Non-Medical Transportation		Trip	15594	124.00	30.81	59575941.36	
Nutritional Consultation Total:							110.16
Nutritional Consultation		15 Min	1	8.00	13.77	110.16	
Participant-Directed Community Supports Total:							1782138.88
Participant-Directed Community Supports		Per Purchase	32	158.00	352.48	1782138.88	
Participant-Directed Goods and Services Total:							40984.56
Participant-Directed Goods and Services		Per Purchase	9	4.00	1138.46	40984.56	
Personal Emergency Response System (PERS) Total:							26114140.80
Personal Emergency Response System (PERS)		Month	68160	11.00	34.83	26114140.80	
Pest Eradication Total:							306030.00
Pest Eradication		Per Purchase	202	1.00	1515.00	306030.00	
TeleCare Total:							140146.56
GRAND TOTAL:							5865110949.15
Total: Services included in capitation:							5865110949.15
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							116996
Factor D (Divide total by number of participants):							50130.87
Services included in capitation:							50130.87
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
TeleCare		OneTime,Mnthly,Purcha	348	8.00	50.34	140146.56	
Vehicle Modifications Total:							3549937.44
Vehicle Modifications		Per Adaptation	168	1.00	21130.58	3549937.44	
GRAND TOTAL:							5865110949.15
Total: Services included in capitation:							5865110949.15
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							116996
Factor D (Divide total by number of participants):							50130.87
Services included in capitation:							50130.87
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Daily Living Total:							77732180.00
Adult Daily Living Services		Day, Half Day	5827	200.00	66.70	77732180.00	
Employment Skills Development Total:							1515985.20
Employment Skills Development		15 Min	68	3590.00	6.21	1515985.20	
Job Coaching Total:							164023.20
Job Coaching		15 Min	36	418.00	10.90	164023.20	
Personal Assistance Services Total:							6682826123.82
GRAND TOTAL:							7143156371.03
Total: Services included in capitation:							7143156371.03
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							128146
Factor D (Divide total by number of participants):							55742.33
Services included in capitation:							55742.33
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance Services		15 min	124623	10494.00	5.11	6682826123.82	
Residential Habilitation Total:							55394596.71
Residential Habilitation Services		Per Diem, Hour	601	513.00	179.67	55394596.71	
Respite Total:							2465049.68
Respite Services		15 Min	662	733.00	5.08	2465049.68	
Structured Day Habilitation Services Total:							22861804.10
Structured Day Habilitation Services		Hour	746	887.00	34.55	22861804.10	
Counseling Services Total:							85287.15
Counseling Services		15 Min	61	117.00	11.95	85287.15	
Home Health Aide Services Total:							2050048.35
Home Health Aide Services		15 Min	305	423.00	15.89	2050048.35	
Nursing Services Total:							68569221.60
Nursing Services		15 Min	1826	3240.00	11.59	68569221.60	
Occupational Therapy Services Total:							484155.75
Occupational Therapy Services		15 Min	115	195.00	21.59	484155.75	
Physical Therapy Services Total:							477050.00
Physical Therapy Services		15 Min	250	94.00	20.30	477050.00	
Specialized Medical Equipment and Supplies Total:							3755743.20
Specialized Medical Equipment and Supplies		Per Purchase	8622	36.00	12.10	3755743.20	
Speech and							281048.04
GRAND TOTAL:							7143156371.03
Total: Services included in capitation:							7143156371.03
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							128146
Factor D (Divide total by number of participants):							55742.33
Services included in capitation:							55742.33
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Language Therapy Services Total:							
Speech and Language Therapy Services		15 Min	69	182.00	22.38	281048.04	
Assistive Technology Total:							24874.29
Assistive Technology		Per Purchase	41	7.00	86.67	24874.29	
Behavior Therapy Total:							3294569.70
Behavior Therapy		15 Min	387	405.00	21.02	3294569.70	
Benefits Counseling Total:							156.80
Benefits Counseling		15 Min	1	14.00	11.20	156.80	
Career Assessment Total:							430.65
Career Assessment		15 Min	1	33.00	13.05	430.65	
Cognitive Rehabilitation Therapy Services Total:							2600219.70
Cognitive Rehabilitation Therapy Services		15 Min	234	769.00	14.45	2600219.70	
Community Integration Total:							323975.70
Community Integration		15 Min	69	705.00	6.66	323975.70	
Community Transition Services Total:							1743860.96
Community Transition Services		Per Purchase	716	2.00	1217.78	1743860.96	
Home Adaptations Total:							44050669.92
Home Adaptations		Per Adaptation	5364	4.00	2053.07	44050669.92	
Home Delivered Meals Total:							70110134.94
Home Delivered Meals		Per Purchase	37033	278.00	6.81	70110134.94	
GRAND TOTAL:						7143156371.03	
Total: Services included in capitation:						7143156371.03	
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:						128146	
Factor D (Divide total by number of participants):						55742.33	
Services included in capitation:						55742.33	
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Job Finding Total:							12394.80
Job Finding		15 Min	11	90.00	12.52	12394.80	
Non-Medical Transportation Total:							66951208.80
Non-Medical Transportation		Trip	17080	126.00	31.11	66951208.80	
Nutritional Consultation Total:							111.20
Nutritional Consultation		15 Min	1	8.00	13.90	111.20	
Participant-Directed Community Supports Total:							2006060.00
Participant-Directed Community Supports		Per Purchase	35	161.00	356.00	2006060.00	
Participant-Directed Goods and Services Total:							45993.60
Participant-Directed Goods and Services		Per Purchase	10	4.00	1149.84	45993.60	
Personal Emergency Response System (PERS) Total:							28889991.90
Personal Emergency Response System (PERS)		Month	74655	11.00	35.18	28889991.90	
Pest Eradication Total:							338163.15
Pest Eradication		Per Purchase	221	1.00	1530.15	338163.15	
TeleCare Total:							174330.36
TeleCare		OneTime,Mnthly,Purchase	381	9.00	50.84	174330.36	
Vehicle Modifications Total:							3926907.76
Vehicle Modifications		Per Adaptation	184	1.00	21341.89	3926907.76	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							7143156371.03 7143156371.03 128146 55742.33 55742.33 337

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (8 of 9)****d. Estimate of Factor D.**

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Daily Living Total:							87294610.13
Adult Daily Living Services		Day, Half Day	6383	203.00	67.37	87294610.13	
Employment Skills Development Total:							1689815.16
Employment Skills Development		15 Min	74	3642.00	6.27	1689815.16	
Job Coaching Total:							181896.00
Job Coaching		15 Min	39	424.00	11.00	181896.00	
Personal Assistance Services Total:							7652261656.20
Personal Assistance Services		15 min	136493	10865.00	5.16	7652261656.20	
Residential Habilitation Total:							62302294.94
Residential Habilitation Services		Per Diem, Hour	659	521.00	181.46	62302294.94	
Respite Total:							2768789.50
Respite Services		15 Min	725	743.00	5.14	2768789.50	
Structured Day Habilitation Services Total:							25654617.00
Structured Day Habilitation Services		Hour	817	900.00	34.89	25654617.00	
GRAND TOTAL:							8167769662.00
Total: Services included in capitation:							8167769662.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							140352
Factor D (Divide total by number of participants):							58195.00
Services included in capitation:							58195.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Counseling Services Total:							96234.11
Counseling Services		15 Min	67	119.00	12.07	96234.11	
Home Health Aide Services Total:							2306625.75
Home Health Aide Services		15 Min	335	429.00	16.05	2306625.75	
Nursing Services Total:							76892400.00
Nursing Services		15 Min	2000	3286.00	11.70	76892400.00	
Occupational Therapy Services Total:							544115.88
Occupational Therapy Services		15 Min	126	198.00	21.81	544115.88	
Physical Therapy Services Total:							533875.30
Physical Therapy Services		15 Min	274	95.00	20.51	533875.30	
Specialized Medical Equipment and Supplies Total:							4158004.32
Specialized Medical Equipment and Supplies		Per Purchase	9444	36.00	12.23	4158004.32	
Speech and Language Therapy Services Total:							316038.40
Speech and Language Therapy Services		15 Min	76	184.00	22.60	316038.40	
Assistive Technology Total:							27575.10
Assistive Technology		Per Purchase	45	7.00	87.54	27575.10	
Behavior Therapy Total:							3699624.72
Behavior Therapy		15 Min	424	411.00	21.23	3699624.72	
Benefits Counseling Total:							316.68
Benefits						316.68	
GRAND TOTAL:							8167769662.00
Total: Services included in capitation:							8167769662.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							140352
Factor D (Divide total by number of participants):							58195.00
Services included in capitation:							58195.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Counseling		15 Min	2	14.00	11.31		
Career Assessment Total:							896.24
Career Assessment		15 Min	2	34.00	13.18	896.24	
Cognitive Rehabilitation Therapy Services Total:							2915328.00
Cognitive Rehabilitation Therapy Services		15 Min	256	780.00	14.60	2915328.00	
Community Integration Total:							366219.68
Community Integration		15 Min	76	716.00	6.73	366219.68	
Community Transition Services Total:							1928577.28
Community Transition Services		Per Purchase	784	2.00	1229.96	1928577.28	
Home Adaptations Total:							48729600.00
Home Adaptations		Per Adaptation	5875	4.00	2073.60	48729600.00	
Home Delivered Meals Total:							78692889.60
Home Delivered Meals		Per Purchase	40560	282.00	6.88	78692889.60	
Job Finding Total:							13813.80
Job Finding		15 Min	12	91.00	12.65	13813.80	
Non-Medical Transportation Total:							75259009.28
Non-Medical Transportation		Trip	18707	128.00	31.43	75259009.28	
Nutritional Consultation Total:							224.64
Nutritional Consultation		15 Min	2	8.00	14.04	224.64	
Participant-Directed Community Supports Total:							2227114.64
GRAND TOTAL:							8167769662.00
Total: Services included in capitation:							8167769662.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							140352
Factor D (Divide total by number of participants):							58195.00
Services included in capitation:							58195.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant-Directed Community Supports		Per Purchase	38	163.00	359.56	2227114.64	
Participant-Directed Goods and Services Total:							51098.96
Participant-Directed Goods and Services		Per Purchase	11	4.00	1161.34	51098.96	
Personal Emergency Response System (PERS) Total:							31956605.78
Personal Emergency Response System (PERS)		Month	81766	11.00	35.53	31956605.78	
Pest Eradication Total:							373998.90
Pest Eradication		Per Purchase	242	1.00	1545.45	373998.90	
TeleCare Total:							193178.70
TeleCare		OneTime,Mnthly,Purcha	418	9.00	51.35	193178.70	
Vehicle Modifications Total:							4332617.31
Vehicle Modifications		Per Adaptation	201	1.00	21555.31	4332617.31	
GRAND TOTAL:							8167769662.00
Total: Services included in capitation:							8167769662.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							140352
Factor D (Divide total by number of participants):							58195.00
Services included in capitation:							58195.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Daily Living Total:							97959501.36
Adult Daily Living Services		Day, Half Day	6989	206.00	68.04	97959501.36	
Employment Skills Development Total:							1894024.62
Employment Skills Development		15 Min	81	3694.00	6.33	1894024.62	
Job Coaching Total:							205423.90
Job Coaching		15 Min	43	430.00	11.11	205423.90	
Personal Assistance Services Total:							8760927600.00
Personal Assistance Services		15 min	149472	11250.00	5.21	8760927600.00	
Residential Habilitation Total:							69772496.64
Residential Habilitation Services		Per Diem, Hour	721	528.00	183.28	69772496.64	
Respite Total:							3107128.44
Respite Services		15 Min	794	754.00	5.19	3107128.44	
Structured Day Habilitation Services Total:							28795837.40
Structured Day Habilitation Services		Hour	895	913.00	35.24	28795837.40	
Counseling Services Total:							106784.40
Counseling Services		15 Min	73	120.00	12.19	106784.40	
Home Health Aide Services Total:							2586726.96
Home Health Aide Services		15 Min	366	436.00	16.21	2586726.96	
Nursing Services Total:							86277371.40
Nursing Services		15 Min	2190	3333.00	11.82	86277371.40	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							9337911470.16 9337911470.16 153698 60754.93 60754.93 337

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy Services Total:							610790.76
Occupational Therapy Services		15 Min	138	201.00	22.02	610790.76	
Physical Therapy Services Total:							596448.00
Physical Therapy Services		15 Min	300	96.00	20.71	596448.00	
Specialized Medical Equipment and Supplies Total:							4725776.90
Specialized Medical Equipment and Supplies		Per Purchase	10342	37.00	12.35	4725776.90	
Speech and Language Therapy Services Total:							354344.43
Speech and Language Therapy Services		15 Min	83	187.00	22.83	354344.43	
Assistive Technology Total:							30943.50
Assistive Technology		Per Purchase	50	7.00	88.41	30943.50	
Behavior Therapy Total:							4138434.56
Behavior Therapy		15 Min	464	416.00	21.44	4138434.56	
Benefits Counseling Total:							320.04
Benefits Counseling		15 Min	2	14.00	11.43	320.04	
Career Assessment Total:							905.76
Career Assessment		15 Min	2	34.00	13.32	905.76	
Cognitive Rehabilitation Therapy Services Total:							3264615.20
Cognitive Rehabilitation Therapy Services		15 Min	280	791.00	14.74	3264615.20	
Community							409151.82
GRAND TOTAL:							9337911470.16
Total: Services included in capitation:							9337911470.16
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							153698
Factor D (Divide total by number of participants):							60754.93
Services included in capitation:							60754.93
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integration Total:							
Community Integration		15 Min	83	726.00	6.79	409151.82	
Community Transition Services Total:							2134202.68
Community Transition Services		Per Purchase	859	2.00	1242.26	2134202.68	
Home Adaptations Total:							53899934.24
Home Adaptations		Per Adaptation	6434	4.00	2094.34	53899934.24	
Home Delivered Meals Total:							88287670.90
Home Delivered Meals		Per Purchase	44417	286.00	6.95	88287670.90	
Job Finding Total:							15438.93
Job Finding		15 Min	13	93.00	12.77	15438.93	
Non-Medical Transportation Total:							84529333.20
Non-Medical Transportation		Trip	20486	130.00	31.74	84529333.20	
Nutritional Consultation Total:							255.24
Nutritional Consultation		15 Min	2	9.00	14.18	255.24	
Participant-Directed Community Supports Total:							2456777.40
Participant-Directed Community Supports		Per Purchase	41	165.00	363.16	2456777.40	
Participant-Directed Goods and Services Total:							56301.60
Participant-Directed Goods and Services		Per Purchase	12	4.00	1172.95	56301.60	
Personal Emergency Response System (PERS) Total:							35349891.39
GRAND TOTAL:							9337911470.16
Total: Services included in capitation:							9337911470.16
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							153698
Factor D (Divide total by number of participants):							60754.93
Services included in capitation:							60754.93
Services not included in capitation:							
Average Length of Stay on the Waiver:							337

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System (PERS)		Month	89541	11.00	35.89	35349891.39	
Pest Eradication Total:							413641.15
Pest Eradication		Per Purchase	265	1.00	1560.91	413641.15	
TeleCare Total:							213808.14
TeleCare		OneTime,Mnthly,Purcha	458	9.00	51.87	213808.14	
Vehicle Modifications Total:							4789589.20
Vehicle Modifications		Per Adaptation	220	1.00	21770.86	4789589.20	
GRAND TOTAL:							9337911470.16
Total: Services included in capitation:							9337911470.16
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							153698
Factor D (Divide total by number of participants):							60754.93
Services included in capitation:							60754.93
Services not included in capitation:							
Average Length of Stay on the Waiver:							337