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:
Pennsylvania Adult Autism Waiver

C. Waiver Number:PA.0593

D. Amendment Number:PA.0593.R02.05

E. Proposed Effective Date: (mm/dd/yy)
01/01/20

Approved Effective Date of Waiver being Amended: 07/01/16

2. Purpose(s) of Amendment

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

In Appendix A, Role of Local/Regional Non-State Entities has been changed from Not Applicable to Applicable to include Local/Regional non-state public agencies and Local/Regional non-governmental non-state entities. Language to specify the nature of these agencies has been added. Items A-5, A-6 and A-7 have been revised as well.
In Appendix B, Reserved Capacity was added to serve 15 participants in waiver years (WYs) 4 and 5 who need to be re-enrolled in the Adult Autism Waiver (AAW) after a stay in a hospital or rehabilitative care for more than 30 days.
In Appendix B, the number of unduplicated participants and maximum number of participants served is being updated to reflect current allowable waiver capacity.
Also in Appendix B, Selection of Entrants to the Waiver, Priority 2 status is removed and the Intake Process is revised and Interest List Procedure is revised to change the Interest List to a Wait List. Change in Priority status has been removed.
In Appendix C, a new service, non-medical Transportation, is being added.
Also in Appendix C, validation of provider qualifications for all services is being changed from every 30 months to every 36 months to align with a revised quality management strategy.
In Appendix C, the definitions of Day Habilitation and Residential Habilitation were revised to clarify where new facilities can be located.
In Appendix C, provider qualifications for all employment services are revised and clarification is added as to when employment services can be accessed without a referral to OVR.
In Appendix C, language was updated to reflect that family members can provide Transportation-Trip through an OHCDS.
In Appendix C, the educational qualifications for staff providing Career Planning were revised based on public comment.
Appendix I is revised to include a more detailed description of the rate setting methodology.
Revisions were made based on the new Chapter 6100 regulations, as applicable.
Changes were made to performance measures.
ODP changed all references to Family Living to Life Sharing.
ODP changed all references to Supports Coordination Agencies to Supports Coordination Organizations.
ODP changed the name of Transitional Work Service to Small Group Employment.
ODP changed references to the Bureau of Autism Services (BAS) to the Bureau of Supports for Autism and Special Populations (BSASP) or the Office of Developmental Programs (ODP), as applicable.

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**	
☒ **Appendix A Waiver Administration and Operation**	A-4, A-5, A-6
☒ **Appendix B Participant Access and Eligibility**	B-1, B-3, B-6, B-7
☒ **Appendix C Participant Services**	C-1, C-2, C-3
☒ **Appendix D Participant Centered Service Planning and Delivery**	D-1
☐ **Appendix E Participant Direction of Services**	

Component of the Approved Waiver	Subsection(s)
☐ Appendix F Participant Rights	
☒ Appendix G Participant Safeguards	G-1, G-2
☒ Appendix H	H-1
☒ Appendix I Financial Accountability	I-1, I-2, I-3
☒ Appendix J Cost-Neutrality Demonstration	J-1, J2

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:

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*):

Pennsylvania Adult Autism Waiver

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**

Waiver Number:PA.0593.R02.05
Draft ID: PA.006.02.06

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/16
Approved Effective Date of Waiver being Amended: 07/01/16

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

This waiver includes both subcategories of ICF/ID level of care used in Pennsylvania:
Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC); and
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID).

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

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

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

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

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

The Pennsylvania Adult Autism Waiver is designed to provide community-based services and supports to meet the specific needs of adults with Autism Spectrum Disorders (ASD). The intent of this waiver is to serve some of the many people with ASD that are not served by any waiver, including people transitioning from state hospitals and people who need services as part of a protective services plan to prevent abuse and neglect. The Department of Human Services (DHS) established the Office of Developmental Programs (ODP), Bureau of Autism Services (BAS) in February 2007 for the explicit purpose of assuring that people with ASD have supports and services to assist them in leading successful, happy, and safe lives in the community.

As the State Medicaid Agency, DHS retains ultimate authority over the administration and implementation of the Adult Autism Waiver. ODP is responsible for developing policies and procedures for waiver operations. Individuals request services through a toll free number at ODP. ODP regional staff and ODP contractors assess functional eligibility for the Adult Autism Waiver. The DHS Office of Income Maintenance (OIM) determines financial eligibility.

The Adult Autism Waiver offers Supports Coordination as a waiver service. The participant chooses his or her Supports Coordination Organization with assistance from ODP regional staff. The Supports Coordinator then conducts state-specified assessments and works with the participant and individuals he or she chooses to develop an Individual Support Plan (ISP). The waiver offers only agency-managed services. DHS will develop processes to implement participant directed services, consistent with those in other DHS programs, during 2017.

3. Components of the Waiver Request

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

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

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

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

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

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

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

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

geographic area:

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the

individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

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

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

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

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

Appendix H.

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

Through a notice published on September 7, 2019, DHS informed interested persons of the availability of the proposed amendment for public comment. This notice can be accessed online at https://www.pabulletin.com/secure/data/vol49/49-36/index.html and via subscription. The public comment period was open until 11:59pm on October 7, 2019. Written comments were accepted via electronic mail and postal mail. Verbal comments were accepted through a teleconference held on September 16.

The Pennsylvania Bulletin is published weekly under 4 Pa.C.S. Part II (relating to publication and effectiveness of Commonwealth documents). ODP sent notification of the publication via our ListServ that includes providers, Supports Coordination Organizations, advocacy organizations, individuals and families. The notice also indicates that copies of the notice and proposed amendment could be obtained from ODP's Bureau of Autism Services. Tribal Government notice was not required as there are no federally-recognized Tribal Governments that maintain a primary office and/or majority population in Pennsylvania.

ODP received written comments from 37 individuals and organizations regarding the proposed amendment. Approximately 39 telephone lines (this could represent one individual or a group of individuals) were utilized during the teleconference in September. The following is a general summary of comments received on the proposed amendment.

•One comment was received questioning the effective date of the amendment as October 1, 2019.
ODP Response: ODP has changed the proposed implementation date to January 1, 2020. The implementation date is subject to approval from the Centers for Medicare and Medicaid Services (CMS). ODP will confirm the implementation date and final CMS approval of the amendment with stakeholders by written notice via email at the time the amendment is approved by CMS.

•One comment was received in support of the expansion of the maximum number of persons served and the maximum unduplicated number of participants. The comment included a suggestion that more growth is needed in order to address the need for service under the Adult Autism Waiver (AAW).
ODP Response: No changes were made to the waiver based on these comments. The number of persons that can be served in the AAW is dependent upon the Governor's budget and as approved by the Pennsylvania General Assembly.

•One comment was received expressing support for expanding the scope of professionals who can diagnose Autism Spectrum Disorder.
ODP Response: The waiver was submitted with the proposed change intact.

•Four comments were received regarding the transfer of initial Level of Care (LOC) determination for waiver eligibility to the Administrative Entities (AE). One comment was in support of this change and three comments were opposed to the AE's increased workload and lack of expertise in determining LOC for a person with Autism Spectrum Disorder (ASD). One comment asked for clarification on the procedures that would be implemented.
ODP Response: No changes were made based on these comments. An individual who registers with the county and is placed on a waiting list for the Consolidated, Community Living or Person/Family Directed Support waiver must have a LOC completed. Having the AEs complete the LOC for the AAW will remove duplication of LOC determination for persons who wish to be placed on the waiting list for the AAW and other ODP waivers. It also provides the opportunity for a person with ASD seeking enrollment in the AAW to learn about opportunities to enroll in other ODP waivers. ODP is currently developing guidance for the AEs on determining LOC for a person with ASD and the procedures for communication between the AEs and ODP regarding AAW eligibility.

•One comment was received in support of the change in language from "intellectual disability" to "developmental disability" when describing the title and qualifications of a person considered qualified to determine initial Level of Care (LOC).
ODP Response: The waiver was submitted with the proposed change intact.

•One comment was received supporting the proposed transition from an interest list to a waiting list and suggesting that ODP immediately implement a system where waiver capacity is filled based on urgency of need rather than first serve applicants that were added to the interest list prior to the implementation of the amendment before beginning to serve applicants based on urgency of need. The suggestion was based on a concern that applicants with greater need could wait for waiver services longer, creating potential health and safety issues.
ODP Response: ODP considers a person's basic health and safety needs to be of the highest priority. Any person with Autism Spectrum Disorder (ASD) who registers with the county and is determined to meet the Level of Care (LOC)

criteria for the AAW will also meet the LOC criteria for ODP's other three waivers. Since those waiver allocations are based on urgency of need, an applicant with potential health and safety issues would be prioritized to be served in one of those waivers. The registration with the county will also allow those applicants to access resources, such as Targeted Support Management, that could mitigate their health and safety risks.

•One comment was received in support of the changes to the performance measure related to Level of Care (LOC) evaluations.
ODP Response: The waiver was submitted with the proposed change intact.

•One comment was received in support of the change to align the AAW with the other ODP waivers in how ODP assesses compliance with the Administrative Entities since the change will promote consistency across all waivers.
ODP Response: The waiver was submitted with the proposed change intact.

The general summary of comments received on the proposed amendment continues in the Main Module - Additional Needed Information

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

7. Contact Person(s)

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

Last Name: Allen

First Name: Leesa

Title: Deputy Secretary

Agency: Department of Human Services, Office of the Secretary

Address: 3rd Floor, Health and Welfare Building

Address 2:

City: Harrisburg

State: **Pennsylvania**

Zip: 17105

Phone:

(717) 787-1870 **Ext:** ☐ **TTY**

Fax:
(717) 772-6366

E-mail:
leallen@pa.gov

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

Last Name:
Mochon

First Name:
Julie

Title:
Policy Director

Agency:
Office of Developmental Programs

Address:
Health & Welfare Building, 625 Forster Street

Address 2:
Room 501

City:
Harrisburg

State: **Pennsylvania**

Zip:
17120

Phone:
(717) 783-5771 **Ext:** ☐ **TTY**

Fax:
(717) 787-6583

E-mail:
jmochon@pa.gov

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: Julie Mochon

State Medicaid Director or Designee

Submission Date: Oct 15, 2019

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

Last Name: Allen

First Name: Leesa

Title: Deputy Secretary

Agency: Department of Human Services, Office of the Secretary

Address: 3rd Floor, Health and Welfare Building

Address 2:

City: Harrisburg

State: **Pennsylvania**

Zip: 17105

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

Fax: (717) 772-6366

E-mail: leallen@pa.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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):

Continuation of Summary of Waiver Comments

•One comment was received in support of the addition of the Reserved Capacity for participants requiring hospital/rehabilitation care beyond 30 consecutive days and up to 6 consecutive months from the first date of leave.
ODP Response: The waiver was submitted with the proposed change intact.

•One comment was received regarding the location where Day Habilitation can be rendered. The comment supported the proposed change but was opposed to using a tiered approach to allow current providers to serve a large number of individuals in licensed facilities that may be in close proximity to other service settings.
ODP Response: No changes were made to the waiver based on this comment. Locations where Day Habilitation can be provided will align with the 55 Pa. Code Chapter 6100 regulations which were developed through an extensive stakeholder engagement process and were unanimously approved by the Independent Regulatory Review Commission.

•One comment was received supporting the addition that participants be offered opportunities and support to participate in community activities that are consistent with the individual's preferences, choices and interests and suggesting that the language be modified to ensure that participants are given informed choice.
ODP Response: No changes were made to the waiver based on this comment. ODP will take this comment into consideration when developing guidance and training related to this change.

•Two comments were received regarding referrals to the Office of Vocational Rehabilitation (OVR) during the closure of the OVR order of selection. Comments were supportive that Supported Employment and Career Planning can be provided without referring the individual to OVR during the closure of the order of selection.
ODP Response: The waiver was submitted with the proposed change intact.

•One comment was received regarding the Supported Employment service requirement that OVR services are considered to not be available to the participant if OVR has not made an eligibility determination within 120 days of the referral being sent. The comment recommended that this be changed to 60 days.
ODP Response: No changes were made based on these comments. ODP and OVR worked closely to establish the 120-day timeframe. This is based on OVR's timeframes for receipt and assignment of the referral, completion of the initial interview, and determination of eligibility in compliance with Rehabilitation Services Administration (RSA) requirements.

•Three comments were received in regard to training and certification requirements for staff providing Supported Employment. The comments suggested the removal of the requirement for ODP training since staff will be required to obtain the Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE) or the 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. Comments also included concerns that the ODP training often yields failing results.
ODP Response: No changes were made to the waiver based on these comments. ODP is currently evaluating the content and testing methods of the ODP training specific to employment services and intends on making modifications to alleviate duplication. ODP will take these comments into consideration when making those modifications.

•One comment was received in support of allowing a participant to receive Supported Employment services through the waiver if the participant has received an offer of competitive integrated employment prior to OVR making an eligibility determination.
ODP Response: The waiver was submitted with the proposed change intact.

•One comment was received in support of the change to prohibit providers of Supported Employment services from also being the employer of the participant to whom they provide Supported Employment.
ODP Response: The waiver was submitted with the proposed change intact.

•One comment was received regarding Small Group Employment. The comment was in support of the change to allow Small Group Employment to be accessed under the waiver without a referral to OVR and supportive of the change to staff qualifications.
ODP Response: The waiver was submitted with the proposed change intact.

•Two comments were received regarding the educational requirements for staff providing Career Planning. The comments suggested relaxing the requirements for specific degrees and experience since staff will be required to obtain the Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE) or the 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.
ODP Response: Based on public comment received, ODP is changing the requirement from Bachelor's or Associate's degree, to high school diploma or equivalent. This change can be made without sacrificing quality of services to participants, as staff working directly with a participant will have to complete certification requirements as proposed in the amendment. This change aligns with the staff qualifications in the other ODP waivers and will better support participants in the AAW to achieve competitive integrated employment.

•One comment was received in support of the addition to the Supports Coordination service definition that clarifies that monitoring includes the review of information in the health risk screening tool or whether there have been any changes in orders, plans or medical interventions prescribed or recommended and whether those changes are being implemented.
ODP Response: The waiver was submitted with the proposed change intact.

•Five comments were received regarding the addition of the Transportation service. One comment was in support of the addition of the service and requested clarification on who can provide the service. Four comments recommended increasing the proposed service limitation of $4500 per participant's service plan year.
ODP Response: No changes were made based on these comments. The service limitation was established based on the average use of the Transportation service in the other ODP waivers.

•Three comments were received regarding the changes to the Residential Habilitation service definition. One comment was supportive of the change to bring the service definition in line with the Home and Community Based (HCBS) Final Rule. Two comments thought that the language for ODP standard orientation and annual training was unclear and provides unilateral authority to ODP to determine orientation and training requirements without stakeholder input.
ODP Response: No changes were made to the waiver based on these comments. This change was made to align with the language in the other ODP waivers. This language aligns with the 55 Pa. Code Chapter 6100 regulations, which were developed through an extensive stakeholder engagement process and were unanimously approved by the Independent Regulatory Review Commission.

•Two comments were received on Specialized Skill Development services. One comment suggested simplifying this service definition and revising the staff qualifications to include to include specific degree requirements or experience, but not both. One comment asked for clarification on the role of the direct support professional with the provision of Systematic Skill Building. Both comments suggested that ODP evaluate the length of time and difficulty of the training course for Systematic Skill Building.
ODP Response: No changes were made to the waiver based on these comments. ODP is currently evaluating the content and testing methods of the ODP training course for Systematic Skill Building and intends on making modifications to the course. ODP will take these comments into consideration when making those modifications.

•One comment was received in support of the changes to the responsibility for the review and response to critical events or incidents.
ODP Response: The waiver was submitted with the proposed change intact.

•One comment was received in support of the addition of a specific requirement for ODP to review unauthorized restraints as part of ODP's oversight procedures.
ODP Response: The waiver was submitted with the proposed change intact.

•One comment was received asking about a potential language change for who attends the Quality Management (QM) meetings described in Appendix H.
ODP Response: ODP is not changing the content of Appendix H in this area since it defines the specific divisions within ODP that must attend the quarterly QM meetings. However, ODP's Bureau of Autism Services (BAS) is now known as the Bureau of Supports for Autism and Special Populations (BSASP) and the name of that bureau will be updated throughout the waiver.

•Thirty-two comments were received related to service reimbursement rates including dissatisfaction with current rates and disclosure of all components of rate setting.
ODP Response: No changes were made to the waiver based on these comments. ODP is in compliance with Federal and State regulations and guidance on rate setting. Rates for the proposed Transportation Trip service are under development and will be released for public comment prior to finalization.

•Two comments were received suggesting that Participant Directed Services (PDS) be added to the AAW.
ODP Response: No changes were made to the waiver based on these comments. The administrative tasks related to administering a PDS model prohibits ODP from adding PDS to the AAW in an efficient manner. Since PDS is not available in

the AAW, ODP included a reserved capacity category called Participant Direction Transfers in the Consolidated, Community Living and Person/Family Directed Support waiver amendments effective November 1, 2018. Each waiver reserves 5 spaces each year (for a total of 15 per year) for individuals who wish to self-direct the majority of their waiver services but are enrolled in the AAW. Notification about this change and the procedures on this process were enumerated in ODP Communication 19-036 published on March 19, 2019.

•Two comments were received suggesting the elimination of the AAW.
ODP Response: No changes were made to the waiver based on these comments. ODP has no plans to eliminate the Adult Autism Waiver.

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 Developmental Programs (ODP), Bureau of Supports for Autism and Special Populations (BSASP)

(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 State Medicaid Director in the Office of Medical Assistance Programs (OMAP) has the authority to authorize waiver approvals and submissions. The Director of the Bureau of Supports for Autism and Special Populations reports directly to the Deputy Secretary of the Office of Developmental Programs, who reports directly to the Secretary of Human Services (the head of the single state Medicaid agency). The Secretary of Human Services meets weekly with the State Medicaid Director and the Deputy Secretary of the Office of Developmental Programs to discuss services for people with developmental disabilities, and the Deputy Secretary meets regularly with the Director of the Bureau of Supports for Autism and Special Populations to discuss autism services including the waiver. In addition, the State Medicaid Director meets monthly with BSASP staff. Therefore, the SMA, through the Secretary of Human Services and OMAP, has ultimate authority over waiver operations.

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.:*

◉ **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:

The Office of Developmental Programs (ODP) has an agreement with County Mental Health/Intellectual Disability (MH/ID) programs under the control of local elected officials to perform delegated waiver and operational administrative functions. The 55 Pa. Code Chapter 6100 regulations or its regulatory successor authorize Department Designees, Administrative Entities (AEs), to perform waiver administrative functions. Each of these public agencies are delegated functions through an AE Operating Agreement. The AE implements these responsibilities and meets the requirements specified in the AE Operating Agreement. AEs perform the following delegated waiver administration function as of January 1, 2020:
Level of care (LOC) determination – Compile necessary documentation for an LOC determination, review documentation and make a determination regarding whether the applicant/participant meets LOC criteria

ODP retains the authority for all administrative decisions and the oversight of Local/Regional non-state public entities that conduct waiver operational and administrative functions. ODP retains the authority over the administration of the Adult Autism Waiver (AAW), including the development of waiver related policies, rules, and regulations. Regulations, waiver policies, rules and guidelines are distributed by ODP through bulletins and other communications issued electronically.

☒ **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:

When a County MH/ID program is unwilling or unable to perform AE functions, ODP will select a non-governmental entity to perform delegated functions. ODP may select a multi-county MH/ID program or non-profit entity. The 55 Pa. Code Chapter 6100 regulations or its regulatory successor authorize Department Designees, AEs, to perform waiver administrative functions. These public agencies are delegated functions through an AE Operating Agreement. The AE implements these responsibilities and meets the requirements specified in the AE Operating Agreement. A non-governmental entity designated as an AE is delegated the same operational and administrative functions delegated to public agencies. ODP also retains the authority for all administrative decisions and the oversight of non-governmental entities that conduct waiver operational and administrative functions. ODP retains authority over the administration of the AAW, including the development of waiver related policies, rules, and regulations. Regulations, waiver policies, rules and guidelines are distributed by ODP through bulletins and other communications issued electronically.

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:

ODP is responsible for assessing the performance of functions delegated to public agencies and non-governmental entities designated as AEs.

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:

ODP monitors AEs on a three-year cycle to assess compliance with the AE Operating Agreements using a standard ODP Oversight Process review tool. ODP gathers AE performance data annually via a self-assessment of performance of delegated functions. The self-assessment for one-third of the AEs is reviewed and validated by ODP via an on-site review to substantiate compliance during one year of each three year cycle. During this on-site review, ODP verifies that all necessary documentation for an LOC determination is completed in accordance with the AE Operating Agreement.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the 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:
Performance Measure AA1: Number and percent of waiver amendments, renewals and notices in the PA Bulletin reviewed and approved by the State Medicaid Director. Numerator = Number of waiver amendments, renewals and notices in the PA Bulletin reviewed and approved by the State Medicaid Director. Denominator = Number of waiver amendments, renewals and notices in the PA Bulletin.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Autism Waiver PA Bulletin Tracking Spreadsheet

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

Data Aggregation and Analysis:

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

Performance Measure:
Performance Measure AA2: Number and percent of providers with signed Medical Assistance Provider Agreements and ODP Provider Agreements. Numerator = Number of providers with signed Medical Assistance Provider Agreements and ODP Provider Agreements. Denominator = Number of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
BSASP's Provider Enrollment Database

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Performance Measure AA3: Number and percent of waiver openings distributed equitably across all geographic areas covered by the waiver using criteria identified in Appendix B-3.

Numerator = number of waiver openings distributed equitably across all geographic areas covered by the waiver using criteria identified in Appendix B-3. Denominator = number of waiver openings distributed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
BSASP's Participant Tracking Database

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

Data Aggregation and Analysis:

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

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

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.

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.

AA3. Number and percent of waiver openings distributed equitably across all geographic areas covered by the waiver using criteria identified in Appendix B-3. If it is discovered that an error in calculation was made, the distribution will be revised accordingly to reflect the correct calculation.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	21		☒
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

Waiver eligibility is limited to people who:

Meet Medical Assistance Program clinical and financial eligibility for Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) services,and

Have a diagnosis of Autism Spectrum Disorder (ASD) manifested before the age of 22 as determined by a licensed psychologist, certified school psychologist, psychiatrist, developmental pediatrician, licensed physician, licensed physician assistant, or certified registered nurse practitioner using the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) applicable at the time of the diagnosis, and

Have substantial functional limitations in three or more major life activities as a result of ASDs and/or other developmental disabilities that are likely to continue indefinitely: self-care, receptive and expressive language, learning, mobility, self-direction and/or capacity for independent living, and

Are 21 years of age or older, and

Are residents of Pennsylvania.

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:

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	702
Year 2	702
Year 3	754
Year 4	754
Year 5	754

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	668
Year 2	668
Year 3	718
Year 4	718
Year 5	718

Appendix B: Participant Access and Eligibility

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

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

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
People transferring from the Adult Community Autism Program	
People discharged from a state hospital	
People identified in Adult Protective Services investigations	
Hospital/Rehabilitation Care	

Appendix B: Participant Access and Eligibility

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

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

People transferring from the Adult Community Autism Program

Purpose *(describe):*

Capacity is reserved to enable adults with ASD who are have been enrolled in the Adult Community Autism Program (ACAP) to transfer to the Adult Autism Waiver. Individuals transferring to the Waiver must meet the eligibility requirements for the Adult Autism Waiver as specified in Appendix B-1, B-4, B-5, and B-6.

All participants enrolled in the AAW have comparable access to all services offered in the Waiver regardless of whether he or she is enrolled due to meeting reserved capacity criteria or the Selection of Entrants to the Waiver criteria in Appendix B-3-f. All participants must go through the Individual Support Plan process, including the full exploration of all service options.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is based on the number of adults with ASD in ACAP that have requested to transfer to the AAW in 2014.

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

Waiver Year	Capacity Reserved
Year 1	3
Year 2	3
Year 3	3
Year 4	3
Year 5	3

Appendix B: Participant Access and Eligibility

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

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

People discharged from a state hospital

Purpose *(describe):*

To enable adults with ASD who have been discharged from a state hospital to receive necessary supports to transition to the community, capacity is reserved for adults with ASD who resided in a state hospital for at least 90 consecutive days, are determined ready for discharge and whose discharge plan specifies a need for long-term support. Discharged individuals must still meet the eligibility requirements for the Adult Autism Waiver specified in Appendix B-1, B-4, B-5, and B-6.

All participants enrolled in the Waiver have comparable access to all services offered in the Waiver regardless of whether he or she is enrolled due to meeting reserved capacity criteria or the Selection of Entrants to the Waiver criteria in Appendix B-3-f. All participants must go through the Individual Support Plan process, including the full exploration of all service options.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is based on the historical number of adults with ASD ready for discharge from a state hospital with discharge plans that indicate a need for long-term support.

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

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

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

People identified in Adult Protective Services investigations

Purpose *(describe):*

To enable adults with ASD who have experienced abuse, exploitation, abandonment, and/or neglect to receive waiver services to help prevent future abuse, exploitation, abandonment, or neglect. Capacity is reserved for adults with ASD who have a protective services plan developed pursuant to the Adult Protective Services Act that specifies a need for long-term support. Individuals must be eligible for the Adult Autism Waiver as specified in Appendix B-1, B-4, B-5, and B-6. In addition, capacity is reserved only for individuals who were not receiving a Pennsylvania home and community-based services waiver at the time the protective services plan was developed.

All participants enrolled in the Waiver have comparable access to all services offered in the Waiver regardless of whether he or she is enrolled due to meeting reserved capacity criteria or the Selection of Entrants to the Waiver criteria in Appendix B-3-f. This is evidenced by the Individual Support Plan process that is required for all participants and requires that service options be fully explored with every individual.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is based on the historical number of adults with ASD with protective services plans indicating a need for long-term support.

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

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

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

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

Hospital/Rehabilitation Care

Purpose *(describe):*

ODP reserves waiver capacity for participants requiring hospital/rehabilitation care beyond 30 consecutive days and up to 6 consecutive months from the first date of leave. Settings which are considered hospital/rehabilitation care include medical and psychiatric hospital settings, rehabilitation care programs and nursing homes. Settings which are not considered hospital/rehabilitation care include residential treatment facilities, state mental health hospitals, approved private schools and private and state ICFs/ID.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is determined by the historical average number of participants who have been on hospital/rehabilitation leave for more than 30 consecutive days and up to 6 consecutive months.

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

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	0
Year 4	15
Year 5	15

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:

Individuals who meet reserved capacity criteria are eligible for waiver enrollment as long as the waiver year reserved capacity is still available.

For individuals who do not meet reserved capacity criteria, enrollment priority is given to individuals who meet the following criteria:

- Requested service prior to January 1, 2020;
- Placed on the AAW priority 1 interest list prior to January 1, 2020;
- Not receiving ongoing state funded or state and Federally funded long-term support services (e.g., Medicaid HCBS Waiver supports; ICF/ID; nursing facility; services in a state hospital; Community Residential Rehabilitation Services; services in a Long-Term Structured Residence; Residential Treatment Facility; and extended acute care for people with serious mental illness);
- Aged 18 or older; and
- Meet LOC requirements.

If waiver capacity is not available, individuals that meet the above criteria will be placed on a waiting list until capacity is available. When waiver capacity becomes available, based on date of initial date of placement on the interest list, they will be offered the choice to enroll in the waiver by receiving an application based on two prioritization criteria: geographic distribution and date and time of requests for service.

-Geographic Distribution
ODP allocates waiver capacity on a regional basis to ensure access across the Commonwealth. Four regions are defined as follows:

West: Allegheny, Armstrong, Beaver, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Venango, Warren, Washington, and Westmoreland Counties

Central: Adams, Bedford, Blair, Cambria, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Huntington, Juniata, Lancaster, Lebanon, Lycoming, Mifflin, Montour, Northumberland, Perry, Snyder, Somerset, Union, and York Counties

Southeast: Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties

Northeast: Berks, Bradford, Carbon, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming Counties

When ODP adds new capacity, it will add capacity to each region so that the total waiver capacity is allocated in proportion to Pennsylvania's population age 21 or older in each region, according to the most recent version of the U.S. Census Bureau's Current Population Estimates. Once enrolled, participants may move anywhere in the Commonwealth and continue to be enrolled in the waiver.

Persons ages 18-20:
When waiver capacity is available based on the above prioritization criteria and the person is age 21 or older, ODP will offer the individual a choice to enroll in the waiver by sending the person and representative (if applicable) an application. If waiver capacity is available and the person's age is 18 through 20, ODP will offer enrollment to the next person on the waiting list using the prioritization criteria. If a person is not offered enrollment due to their age, ODP will give that person a choice to enroll in the waiver by sending the person and representative (if applicable) an application once they reach the age of 21 and waiver capacity is again available.

Individuals who do not meet reserved capacity criteria and who request service on or after January 1, 2020, will be added to the waiting list for the other waivers administered through the Office of Developmental Programs (ODP) based on eligibility and prioritization criteria described in those waivers. When no more individuals remain on the AAW specific waiting list as described above, ODP will expand the waiting list for the other waivers to include the AAW. The AAW will be amended to clarify that individuals on that waiting list who meet the eligibility criteria for AAW and who meet prioritization criteria as determined by the Prioritization of Urgency of Need for Services (PUNS) will be offered the opportunity to enroll in AAW.

Intake Process

ODP assists the person or representative if necessary to complete the application and the person or representative may call ODP for assistance. When the person and/or representative returns the application, ODP staff determine whether the person meets the eligibility requirements specified in Appendix B-1. If ODP determines the person is not eligible for the waiver, ODP contacts the next person based on the criteria described in the Prioritization Criteria section above.

Person identified in an Adult Protective Services (APS) investigation as needing long-term support: Referrals of individuals identified during an Adult Protective Services investigation as needing long-term supports will be made to the APS liaison, who is an ODP staff person. The APS liaison is responsible for coordinating the waiver enrollment process within ODP.

People transferring from the Adult Community Autism Program (ACAP): ODP will coordinate the transfer of any individuals from ACAP to the waiver with the ACAP provider. ODP and the ACAP provider will work together to ensure that there is no interruption of services.

Person ready for discharge to the community from a state hospital and in need of long-term support: ODP will consult with the Office of Mental Health and Substance Abuse Services (OMHSAS) to identify individuals who are ready for discharge from an Institution for Mental Disease and will coordinate any identified individual's enrollment in to the waiver. ODP and OMHSAS will work together to ensure that there is no interruption of services.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

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

- (●) **No**
- ( ) **Yes**

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

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

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

Select one:

◉ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☒ **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:

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

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

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

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

Check each that applies:

☒ **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: 1

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:

◉ **Other**

Specify:

Individuals added to the waiver waiting list as of January 1, 2020 will have their initial level of care assessed by Qualified Developmental Disabilities Professionals through their Administrative Entity, a county government agency which is delegated authority for some waiver administration functions through an Administrative Entity Operating Agreement. Once enrolled in the waiver, reevaluations of level of care are determined by the state Medicaid agency.

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:

The AE is responsible to have Qualified Developmental Disability Professional (QDDP) performing level of care evaluations.

Qualified Developmental Disabilities Professional (QDDP) must meet one of the following three criteria:

1. A Master's degree or higher level of education from an accredited college or university and one year of work experience working directly with persons with developmental disabilities;
2. A Bachelor's degree from an accredited college or university and two year's work experience working directly with persons with developmental disabilities; or
3. An Associate's degree or 60 credit hours from an accredited college or university and four year's work experience working directly with persons with developmental disabilities.

The AE is responsible to ensure that no conflict of interest exists in the level of care evaluation process.

AEs may contract with another agency or independent QDDP who meets the criteria above to obtain a QDDP certification of need for an ICF/ID or ICF/ORC level of care in order to ensure a conflict-free determination.

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.

The AEs are responsible for the completion of an initial evaluation of need for level of care. The initial evaluation will be performed by a QDDP.

1. ICF/ID
i. There are four fundamental criteria that must be met prior to an individual being determined eligible for an ICF/ID level of care:

1. Have a diagnosis of intellectual disability;

2. Intellectual disability manifested prior to age 22;

3. Adaptive skill deficits in three or more areas of major life activity based on a standardized adaptive functioning test; and

4. Be recommended for an ICF/ID level of care based on a medical evaluation.

2. Autism Spectrum Disorder ICF/ORC
i. There are four fundamental criteria that must be met prior to an individual with autism spectrum disorder being determined eligible for an ICF/ORC level of care:

1. Have a diagnosis of autism spectrum disorder;

2. Autism spectrum disorder manifested prior to age 22;

3. Adaptive skill deficits in three or more areas of major life activity based on a standardized adaptive functioning test; and

4. Be recommended for an ICF/ORC level of care based on a medical evaluation.

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 Evaluation
The fundamental criteria identified in Appendix B-6-d of this waiver must be met prior to an individual being determined eligible for enrollment in the waiver. The AE is responsible to certify need for an ICF/ID or ICF/ORC level of care based on the evaluation and certification of the QDDP. The following level of care criteria must be met prior to enrollment in the waiver:

The following four criteria must be met to document a diagnosis of autism spectrum disorder and ICF/ORC level of care and determine eligibility upon initial certification:

1. A licensed psychologist, certified school psychologist, psychiatrist, developmental pediatrician, licensed physician, licensed physician's assistant or certified registered nurse practitioner certifies that the individual has autism spectrum disorder as documented in a diagnostic tool.

2. A QDDP certifies that the individual has impairments in adaptive functioning based on the results of a standardized assessment of adaptive functioning which shows the individual has significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility of his or her age and cultural group. The results of the assessment must also show that the individual has substantial adaptive skill deficits in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction and/or capacity for independent living.

3. Documentation substantiates that the individual's autism spectrum disorder and substantial adaptive skill deficits manifested during the developmental period which is from birth up to the individual's 22nd birthday.

4. Documentation on a medical form as a result of a current medical evaluation performed by a licensed physician, physician's assistant, or certified registered nurse practitioner that states the individual is recommended for ICF/ORC level of care or documentation on a Medical Assistance Evaluation form (MA51) as a result of a current medical evaluation completed by a licensed physician, physician's assistant, or certified registered nurse practitioner that indicates the individual is recommended for an ICF/ORC level of care.

The following four criteria must be met to document a diagnosis of intellectual disability and ICF/ID level of care and determine eligibility upon initial certification:

1. A licensed psychologist, certified school psychologist, psychiatrist, developmental pediatrician, or licensed physician who practices psychiatry certifies that the individual has significantly sub-average intellectual functioning based on a standardized general intelligence test which is documented by either:
a. Performance that is more than two standard deviations below the mean of a standardized general intelligence test, which reflects a Full Scale IQ score of 70 or below; or
b. Performance that is slightly above two standard deviations below the mean of a standardized general intelligence test during a period when the individual manifests serious impairments of adaptive functioning.

2. A QDDP certifies that the individual has impairments in adaptive functioning based on the results of a standardized assessment of adaptive functioning which shows the individual has significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility of his or her age and cultural group. The results of the assessment must also show that the individual has substantial adaptive skill deficits in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction and/or capacity for independent living.

3. Documentation substantiates that the individual's intellectual and substantial adaptive skill deficits manifested during the developmental period which is from birth up to the individual's 22nd birthday.

4. Documentation on a medical form as a result of a current medical evaluation performed by a licensed physician, physician's assistant, or certified registered nurse practitioner that states the individual is recommended for ICF/ID level of care or documentation on a Medical Assistance Evaluation form (MA51) as a result of a current medical evaluation completed by a licensed physician, physician's assistant, or certified registered nurse practitioner that indicates the individual is recommended for an ICF/ID level of care.

Reevaluation Process
Applicants who have been determined by the AE to meet program eligibility requirements specified in Appendix B-1, upon enrollment and then annually thereafter are evaluated by a physician, physician's assistant, or nurse practitioner licensed in the United States, using the MA51 to determine level of care.

The MA51 is used to determine annual reevaluation of level of care for individuals enrolled in AAW and must be completed within 365 days of the previous MA51.

If the MA51 indicates a person meets ICF/ID level of care criteria, ODP will assign a QDDP to assess whether the person requires ICF/ID level of care using the criteria in B-6-d.

For reevaluations, Supports Coordinators assist physicians, physician's assistants, or certified registered nurse practitioners, licensed in the United States with completing the MA51 when necessary.

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

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

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

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

Once enrolled in the waiver, level of care reevaluations are determined by the state Medicaid agency by persons who have at least three years of professional experience developing, implementing, or evaluating a human service program, and a bachelor's degree; or an equivalent combination of experience and training. Reevaluations are based on Supports Coordinators performing assessments and gathering information that is necessary to make an LOC determination as well as diagnoses and LOC recommendation made may by a physician, physician’s assistant, or certified registered nurse practitioner licensed in the United States.

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 Home and Community Services Information System (HCSIS) sends an alert to the ODP staff and the Supports Coordinator 60 days before the level of care determination is due. The Supports Coordinator also assists physicians with completing the medical evaluation form when necessary.

After the level of care recertification is completed, ODP staff indicate in HCSIS that level of care was reevaluated, and the result of that reevaluation.

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:

Records of all initial level of care evaluations are maintained at the AE office where the participant is registered, per the AE Operating Agreement.

ODP maintains copies of all level of care reevaluations.

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:
Performance Measure LOC1: Number and percent of new enrollees who have a level of care (LOC) completed prior to entry into the waiver. Numerator = Number of new enrollees who have an LOC completed prior to entry into the waiver. Denominator = Number of new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Home and Community Services Information System (HCSIS)

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
Performance Measure LOC2: Number and percent of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver are used. Numerator = Number of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver are used. Denominator = Number of initial LOC determinations.

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

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

For Performance Measure LOC1, a 100% review of data from HCSIS is conducted monthly by ODP staff to assess compliance.

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.

LOC2. ODP evaluates whether initial level of care determinations are completed accurately according to ODP policies and procedures. The AE must complete level of care evaluations using ODP's forms and processes. The AE is required to document remediation actions and submit the documentation to ODP within 30 days. When documentation is located or completed and eligibility in any one of the criteria is not met, disenrollment procedures will be initiated as per ODP policies and procedures. If a determination is made that an AE is incorrectly applying the criteria and making determinations that are incorrect, targeted technical assistance is provided to the AE in order to ensure the AE fully understands the process and applies it correctly. ODP will initiate actions as needed to resolve any outstanding issues with AE performance using the methodology outlined in the AE Operating Agreement.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

ODP sends notification of freedom of choice between the Adult Autism Waiver, institutional services,or no services with the application for the waiver.

If an applicant is determined to meet the criteria in Appendix B-1-b, ODP will send the applicant a list of Supports Coordination Organizations when he or she receives an application for the Adult Autism Waiver. The participant will choose their Supports Coordination Organization with assistance from ODP staff if necessary. The Supports Coordinator will then work with the participant and individuals he or she chooses to develop an ISP as specified in Appendix D. This process includes providing a statewide provider directory to the participant, so he or she is aware of all available providers.

The Supports Coordinator will notify the participant or his or her legal representative in writing that the participant has freedom of choice among feasible service delivery alternatives.

To document that the person has been notified of his or her freedom of choice, ODP developed three forms. A Waiver Service Supports Coordinator Choice Form documents the person was notified of his or her right to choose a supports coordination organization. A Service Delivery Preference Form documents the participants choice between waiver, institutional services, or no services. A Waiver Service Provider Choice Form documents that the person received a list of available providers and has been informed of his or her freedom to choose willing and qualified providers.

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.

Supports Coordinators will maintain copies of forms documenting freedom of choice in the participants record located at the Supports Coordination Organization.

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):

Materials will include a statement in five languages - Spanish, Chinese, Cambodian, Vietnamese and Russian - to inform individuals with Limited English Proficiency (LEP) that they may have the document translated free of charge by calling a toll free number established by DHS that will connect them to an interpreter service. The DHS Office of Administration, Bureau of Equal Opportunity, coordinates LEP issues for DHS and has identified the specific languages to include based upon analysis of the non-English speaking population in accordance with state and Federal policy for access to services for people with LEP. DHS contracts with a telephone interpreter service that staffs the toll-free number and has translators for many languages spoken in the Commonwealth, including less common languages that will not be included in the written materials. Additionally, the Commonwealth has a statewide language interpretation contract that provides access to over thirty contractors who can provide translation and interpretation services via phone, writing or face-to-face.

If a person leaves a message in a language other than English on the toll-free number for requesting services described in Appendix B-3-f, ODP contacts the DHS telephone interpreter service, which will translate the message and translate ODP return of phone call.

The telephone interpreter service will translate for ODP staff in other phone calls to people with LEP. DHS will arrange for in-person translation services to translate in-person interviews by ODP staff or contractors, including initial functional eligibility assessments and interviews for quality monitoring.

Arrangements for accommodating individuals who are deaf or hearing impaired will be made as needed.

Waiver participants with LEP are identified during the enrollment process. ODP ensures that the supports coordinator is aware of the LEP and will use translation services. The supports coordinator must notify other providers of the need for translation services. Upon annual monitoring, ODP will monitor for the use of translation services by that participant's providers.

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	**Day Habilitation**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Statutory Service	**Supports Coordination**		
Extended State Plan Service	**Therapies**		
Other Service	**Assistive Technology**		
Other Service	**Career Planning**		
Other Service	**Community Transition Services**		
Other Service	**Family Support**		
Other Service	**Home Modifications**		
Other Service	**Nutritional Consultation**		
Other Service	**Small Group Employment**		
Other Service	**Specialized Skill Development**		
Other Service	**Temporary Supplemental Services**		
Other Service	**Transportation**		
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:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Day Habilitation is provided in adult training facilities licensed under 55 PA Code Chapter 2380, which are settings other than the participant's private residence, and meet the federal requirements for HCBS settings. This service also includes day habilitation activities in general public community settings, which are non-disability specific settings and meet the federal requirements for HCBS settings. When provided in community locations, this service does not take place in licensed facilities, or any type of facility owned, leased or operated by a provider of other ODP services.

Day Habilitation provides individualized assistance with acquiring, retaining, and improving communication, socialization, self-direction, self-help, and adaptive skills necessary to reside in the community. The service is expected to help the participant develop and sustain a range of valued social roles and relationships; build natural supports; increase independence; and experience meaningful community participation and inclusion. To achieve this, each participant must be offered opportunities and needed support to participate in community activities that are consistent with the individual's preferences, choices and interests. This service includes:

- activities to improve the participant's capacity to perform activities of daily living (i.e., bathing, dressing, eating, mobility, and using the toilet) and instrumental activities of daily living (i.e., communication, survival skills, cooking, housework, shopping, money management, time management, and use of transportation),
- on-site modeling of behavior, behavior support, intensive behavior episode intervention, training, cueing, and/or supervision,
- planning and coordinating a participant's daily/weekly schedule for day habilitation services,
- personal assistance in completing activities of daily living and instrumental activities of daily living, and
- assistance with medication administration and the performance of health-related tasks to the extent state law permits.

The intent of this service, however, is to reduce the need for direct personal assistance by improving the participant's capacity to perform activities of daily living and instrumental activities of daily living independently.

This service also includes transportation to and from the facility and during day habilitation activities necessary for the individual's participation in those activities. The Day Habilitation provider is responsible to provide at least one complete meal,consistent with the individual's dietary needs, if the participant is at the facility for 4 or more hours. If a participant is at the facility for more than 6 hours, a nutritional snack shall also be provided.

Day Habilitation services must be necessary to achieve the expected outcomes identified in the participant's ISP. The Supports Coordinator must review this service at least quarterly, in conjunction with the participant, to assure that expected outcomes are met and to modify the ISP as necessary. The review must include an assessment of the participant's progress, identification of needs, and plans to address those needs. If the participant receives Specialized Skill Development services, this service includes implementation of the behavioral support plan (BSP), the crisis intervention plan (CIP) and/or the Systematic Skill Building plan (SBP). This service includes collecting and recording the data necessary to support review of the Individual Support Plan (ISP), the BSP and the SBP.

Day Habilitation is normally furnished for up to 6 hours a day, five days per week on a regularly scheduled basis. Day Habilitation does not include services that are funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education and Improvement Act. Day Habilitation may not be provided to a participant during the same hours that Supported Employment (when provided directly to the participant), Small Group Employment, quarter hourly-reimbursed Respite or Specialized Skill Development/Community Support is provided.

Travel time to pick up and drop off the participant may not be billed as these costs are assumed in the rate for this service. Transporting the participant to and from activities integral to services provided during the Day Habilitation service day may be billed.

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

Total combined hours for Specialized Skill Development/Community Support, Day Habilitation, Supported Employment (Intensive Job Coaching, Direct and Extended Employment Supports, Direct), and Small Group Employment are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must request an exception to the limit consistent with ODP policy.

Beginning 7/1/19, a participant may not receive Day Habilitation services in a licensed Adult Training Facility for more than 75 percent of his or her support time, on average, per month.

A participant may request an exception to this limitation. The exception request must be submitted in writing to ODP by the participant's Supports Coordinator on behalf of the participant, using a form designated by ODP.

Day Habilitation may not be provided in a licensed Adult Training Facility that is newly funded on or after January 1, 2020 and serves more than 25 individuals in the facility at any one time including individuals funded through any source.

Beginning 1/1/22, Day Habilitation services may not be provided in any facility required to hold a 2380 license that serves more than 150 individuals at any one time including individuals funded through any source.

Day Habilitation may not be provided in a licensed facility that enrolls on or after the effective date of 55 Pa. Code Chapter 6100 regulations in a location that is adjacent to, attached to or located in the same building as any of the following regardless of the funding source of the individuals served:
- Hospital (medical or psychiatric).
- Skilled Nursing Facility (55 Pa. Code Chapters 201 through 211).
- Licensed public or private ICF/ID (55 Pa. Code Chapter 6600) or ICF/ORC.
- Licensed Child Residential Services (55 Pa. Code Chapter 3800).
- Licensed Community Residential Rehabilitation Services for the Mentally Ill (CRRS) (55 Pa. Code Chapter 5310).
- Licensed Personal Care Homes (55 Pa. Code Chapter 2600).
- Licensed Assisted Living Residences (55 pa. Code Chapter 2800).
- Unlicensed or Licensed Family Living Homes (55 Pa. Code Chapter 6500).
- Unlicensed or Licensed Community Homes for Individuals with an Intellectual Disability or Autism (55 Pa. Code Chapter 6400).
- Licensed Adult Training Facilities (55 Pa. Code Chapter 2380).
- Licensed Vocational Facilities (55 Pa. Code Chapter 2390).
- Licensed Older Adult Daily Living Centers (6 Pa. Code Chapter 11).

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 Training Facilities

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Adult Training Facilities

Provider Qualifications

License *(specify):*

Title 55 PA Code Chapter 2380

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Have a waiver service location in Pennsylvania.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Provider staff furnishing this service must:
•Be age 18 or older
•If transporting participants, have a valid driver's license and automobile insurance.
•Have a high school diploma or equivalent
•Complete standard ODP required orientation and annual training, and meet the requirements of 55 Pa. Code Chapter 2380.

Facilities must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of this service

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Residential habilitation assists individuals in acquiring, retaining, and improving the communication, socialization, self-direction, self-help, and adaptive skills necessary to reside in the community when services provided in a more integrated setting cannot meet the participant's health and safety needs. This service also includes any necessary assistance in performing activities of daily living (i.e., bathing, dressing, eating, mobility, and using the toilet) and instrumental activities of daily living (i.e., communication, survival skills, cooking, housework, shopping, money management, time management, and use of transportation). The intent of this service, however, is to reduce the need for direct personal assistance by improving the participant's capacity to perform these tasks independently.

This service includes the following supports, as appropriate to address the participant's goals, as documented in the participant's ISP and to enable the participant to:

1. Carry out activities of daily living such as personal grooming and hygiene, dressing, making meals and maintaining a clean environment.
2. Develop and maintain positive interactions and relationships with residents of one home and share meals and activities, as appropriate.
3. Learn and develop practices that promote good health and wellness such as nutritious meal planning, regular exercise, carrying out prescribed therapies and exercises, awareness and avoidance of risk including environmental risks, exploitation or abuse; responding to emergencies in the home and community such as fire or injury; knowing how and when to seek assistance.
4. Manage or participate in management of medical care including scheduling and attending medical appointments, filling prescriptions and self-administration of medications, and keeping health logs and records.
5. Manage his or her emotional wellness including self-management of emotional stressors and states such as disappointment, frustration, anxiety, anger, depression, and access mental health services.
6. Participate in, and when preferred, direct the person-centered planning process.
7. Develop or expand decision making skills, including identifying options/choices and evaluating options/choices against personal preferences and desired goals. This includes assistance with identifying supports available within the community.
8. Promote financial stability through management of personal resources, general banking and balancing accounts, record keeping, managing savings accounts and participating in programs such as ABLE accounts.
9. Communicate with providers, caregivers, family members, friends and others face-to-face and through the use of the telephone, correspondence, the internet, and social media, consistent with the participant's preferences. The service may require knowledge and use of sign language or interpretation for participants whose primary language is not English.
10. Be mobile by assisting him or her with using a range of transportation options including buses, trains, cab services, driving, and joining car pools, etc.
11. Develop and manage relationships with other residents of the same home and, as appropriate, share responsibilities for shared routines such as preparing meals, eating together, carrying out routine home maintenance such as light cleaning, planning and scheduling shared recreational activities and other typical household routines, resolving differences and negotiating solutions.
12. Develop and maintain relationships with members of the broader community and to manage problematic relationships.
13. Exercise rights as a citizen and fulfill his or her civic responsibilities such as voting and serving on juries; attending public community meetings; to participate in community projects and events with volunteer associations and groups; to serve on public and private boards, advisory groups, and commissions, as well as develop confidence and skills to enhance his or her contributions to the community.
14. Develop personal interests such as hobbies, appreciation of music, and other experiences the participant enjoys or may wish to explore.
15. Participate in preferred activities of community life such as shopping or going to restaurants, museums, movies, concerts and faith-based services.

This service includes transportation to community activities not included in the Medicaid State Plan or other services in this waiver. Those transportation costs are built into the rate for this service.

To the extent that Residential Habilitation is provided in community settings outside of the residence, those settings must be inclusive in the community rather than segregated.

Residential Habilitation does not include payment for room or board.

Residential Habilitation services must be necessary to achieve the expected outcomes identified in the participant's ISP. Prior to Residential Habilitation services being authorized, the SC, in collaboration with the ISP team, must justify the need for Residential Habilitation services by completing a Residential Habilitation Request Form. This process is designed to ensure that services are provided in the most integrated environment.

Residential Habilitation providers must ensure that each participant has the right to the following:
1. To receive scheduled and unscheduled visitors and to communicate and meet privately with individuals of their choice at any time.
2. To send and receive mail and other forms of communication, unopened and unread by others.
3. To have unrestricted and private access to telecommunications.
4. To manage and access his or her own finances.
5. To choose any individual with whom they will be sharing a bedroom.
6. To furnish and decorate his or her bedroom and the common areas of the home.
7. To lock his or her bedroom door.
8. To decide what and when to eat and have access to food at any time.
9. To make informed health care decisions.

When any of these rights are modified, the modification must be supported by a specific assessed need, agreed upon by the ISP team and justified in the ISP. When any of these rights are modified due to requirements in a court order, the modification must be included in the service plan and must be followed.

The Residential Habilitation provider shall ensure that a room and board residency agreement, on a form specified by ODP, is executed annually. The provider is responsible to provide a copy of the agreement to the participant's assigned Supports Coordinator annually.

The Supports Coordinator must review this service at least quarterly, in conjunction with the participant, to assure that expected outcomes are met and to modify the ISP as necessary. The review must include an assessment of the participant's progress, identification of needs, and plans to address those needs.

Residential Habilitation is provided in a licensed facility not owned by the participant or a family member. Residential Habilitation is provided in two types of licensed facilities:

•Community Homes for Individuals with an Intellectual Disability or Autism (55 Pa. Code Chapter 6400): A licensed Community Home is a home where services are provided to individuals with an intellectual disability or autism. A Community Home is defined in 55 Pa. Code Chapter 6400 as, "A building or separate dwelling unit in which residential care is provided to one or more individuals with an intellectual disability or autism".
•Family Living Homes licensed under 55 Pa. Code Chapter 6500.

If the participant receives Specialized Skill Development Services, this service includes implementation of the behavioral support plan (BSP), the crisis intervention plan (CIP), and/or the Systematic Skill Building plan (SBP). Residential Habilitation includes collecting and recording the data necessary to support review of the ISP, the BSP and the SBP.

Residential Habilitation Services must be delivered in Pennsylvania.

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

Facility capacity is limited to two participants per Life Sharing Home.

Facility capacity is limited to four or fewer participants per Community Home. A setting that is a duplex, two bilevel units and two side-by-side apartments enrolled to provide waiver services on or after the effective date of 55 Pa. Code Chapter 6100 regulations shall not exceed a program capacity of 4 in both units.

A participant who is receiving Residential Habilitation services in a Community Home where that participant is the only person receiving services in that home may not also receive Specialized Skill Development/Community Support on the same day the participant is receiving Residential Habilitation (Community Home) consistent with ODP policy.

All residential habilitation settings in which Residential Habilitation Services are provided must be integrated and dispersed in the community in noncontiguous locations, and may not be located on campus settings. To meet this requirement, the location of each residential habilitation setting must be separate from any other ODP-funded residential habilitation setting and must be dispersed in the community and not surrounded by, other ODP-funded residential habilitation settings. Locations that share only one common party wall are not considered contiguous. Residential habilitation settings where Residential Habilitation services are provided should be located in the community and surrounded by the general public. New residential habilitation settings or changes to existing residential habilitation settings must be approved by ODP or its designee utilizing the ODP residential habilitation setting criteria. Residential Habilitation may not be provided in a home enrolled on or after the effective date of 55 Pa. Code Chapter 6100 regulations that is adjacent to any of the following regardless of the funding source of the individuals served:

- Licensed public and private (ICF/ID) (55 Pa. Code Chapter 6600) or ICF/ORC.
- Licensed Personal Care Homes (55 Pa. Code Chapter 2600).
- Licensed Assisted Living Residences (55 pa. Code Chapter 2800).
- Licensed Adult Training Facilities (55 Pa. Code Chapter 2380).
- Licensed Vocational Facilities (55 Pa. Code Chapter 2390).
- Licensed Older Adult Daily Living Centers (6 Pa. Code Chapter 11).

Exceptions are allowed for Residential Service locations to share one common party wall with one other Residential Service location funded through ODP's waivers in the form of a duplex, two bilevel units, and two side-by-side apartments. This exception does not extend to Residential Service locations that are not funded through ODP's waivers.

Settings enrolled on or after the effective date of the Chapter 6100 regulations shall not be located in any development or building where more than 25% of the apartments, condominiums or townhouses have waiver funded Residential Habilitation being provided.

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	Life Sharing Provider
Agency	Residential Provider (Community Home)

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:

Life Sharing Provider

Provider Qualifications

License *(specify):*

55 Pa. Code Chapter 6500

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

For all provider types, individuals furnishing this service must:
• Be age 18 or older
• If transporting participants, have a valid driver's license and automobile insurance.
• Have a high school diploma or equivalent
• Complete standard ODP required orientation and annual training, and meet all requirements of 55 Pa. Code Chapter 6500.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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:

Residential Provider (Community Home)

Provider Qualifications

License *(specify):*

55 Pa. Code Chapter 6400

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Community Homes must have a licensed capacity to serve four or fewer residents.

For all provider types, individuals furnishing this service must:
• Be age 18 or older
• Have a high school diploma or equivalent
• If transporting participants, have a valid driver's license and automobile insurance.
• Complete standard ODP required orientation and annual training, and meet requirements of 55 Pa. Code Chapter 6400.

The Residential Habilitation facility must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of this service

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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	Sub-Category
Category 1: 09 Caregiver Support	**Sub-Category 1:** 09011 respite, out-of-home
Category 2: 09 Caregiver Support	**Sub-Category 2:** 09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Respite provides planned or emergency short-term relief to a participant's unpaid caregiver when the caregiver is temporarily unavailable to provide supports due to non-routine circumstances. Respite may be delivered in the participant's home, unlicensed home controlled by a provider or a private home of staff of a Respite provider, a home owned by a Respite agency provider, Family Living home (Title 55 Pa Code Chapter 6500), or Community Home (Title 55 PA Code Chapter 6400). Respite may also be provided in general public community settings such as parks, libraries, museums and stores. Respite may be provided either in or out of the participant's home. Respite services facilitate the participant's social interaction, use of natural supports and typical community services available to all people, and participation in volunteer activities.

This service includes activities to improve the participant's capacity to perform activities of daily living (i.e., bathing, dressing, eating, mobility, and using the toilet) and instrumental activities of daily living (i.e., communication, survival skills, cooking, housework, shopping, money management, time management, and use of transportation). Respite includes on-site modeling of behavior, behavior support, intensive behavior episode intervention, training, cueing, and/or supervision. To the degree possible, the respite provider must maintain the participant's schedule of activities.

If the participant receives Behavioral Specialist Services, this service includes implementation of the behavioral support plan and, if necessary, the crisis intervention plan. The service includes collecting and recording the data necessary to support review of the Individual Support Plan and the behavioral support plan.

Respite services (15 minute unit services only) may not be provided at the same time that Community Support, Day Habilitation, Supported Employment (when provided directly to the participant), or Small Group Employment is provided. This service does not include room and board when delivered in the participant's home. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Travel time may not be billed by the provider as a discrete unit of this service.

Respite is provided as follows:
•In the participant's home or out of the home in units of 15 minutes. Intended to provide short-term respite. Respite does not include room and board when provided in the participant's home.
•Out of the home in units of a day which is defined as 10 or more hours of out of home respite. Intended to provide overnight respite. Respite services when provided outside the home include room and board.

This service may be delivered in Pennsylvania and in states contiguous to Pennsylvania.

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

Expenditure for Respite is limited to 30 times the day unit rate for respite in a licensed facility per year, with the year starting on the ISP plan effective date. The participant may receive both hourly and daily respite during the year as long as the amount of respite does not exceed the amount approved on the participant's ISP. In the event that respite services would be needed beyond the above limits in order to assure health and welfare, an exception to this limit may be requested. In this situation, the SC will convene an ISP meeting of the participant and other team members within 5 business days of the need for an exception being identified to assure the participant's health and welfare through other supports and services, including requesting an exception to the limitation on respite 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
Agency	Respite Provider
Agency	Life Sharing Home
Agency	Community Home

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Respite Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

For all provider types, individuals furnishing this service must:
• Be age 18 or older
• Have a high school diploma or equivalent
• If transporting participants, have a valid driver's license and automobile insurance.
• Complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:

Life Sharing Home

Provider Qualifications

License *(specify):*

Title 55 PA Code Chapter 6500

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

For all provider types, individuals furnishing this service must:
• Be age 18 or older
• If transporting participants, have a valid Driver's license and automobile insurance.
• Have a high school diploma or equivalent
• Complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Community Home

Provider Qualifications

License *(specify):*

Title 55 PA Code Chapter 6400

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

For all provider types, individuals furnishing this service must:
• Be age 18 or older
• If transporting participants, have a valid driver's license and automobile insurance.
• Have a high school diploma or equivalent
• Complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported Employment services are individualized services, for the benefit of a single participant at one time, to provide assistance to participants who need ongoing support to maintain a job in a self-employment or competitive employment arrangement in an integrated work setting in a position that meets a participant's personal and career goals. Participants receiving Supported Employment services must be compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees without disabilities.

Supported Employment may also be used to support a participant who is self-employed to provide ongoing assistance, counseling and guidance once the business has been launched.

Supported Employment is specific to the participant and can be provided both directly to the participant and indirectly for the benefit of the participant. For instance, if the participant has lost skills, or requirements of the job are expected to change, or a co-worker providing natural supports is leaving, the employer may wish to consult with the Supported Employment provider in person, by phone, by email or by text, regarding how best to address that issue and effectively support the participant.

Supported Employment may include personal assistance as an incidental component of the service.

If the participant receives Specialized Skill Development services, the Supported Employment service includes implementation of the behavioral support plan (BSP) the crisis intervention plan (CIP), and/or the Systematic Skill Building plan (SBP). The Supported Employment service includes collecting and recording the data necessary to support review of the Individual Support Plan (ISP), the BSP and the SBP.

Travel time may not be billed by the provider as a discrete unit of this service.

Supported Employment may be delivered in Pennsylvania and in states contiguous to Pennsylvania.

Supported Employment includes two components: Intensive Job Coaching and Extended Employment Supports.

Intensive Job Coaching includes onsite job training and skills development, assisting the participant with development of natural supports in the workplace, coordinating with employers, coworkers (including developing coworker supports) and customers, as necessary, to assist the participant in meeting employment expectations and addressing issues as they arise, such as training the participants in using public transportation to and from the place of employment. Supported Employment services do not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.

Intensive Job Coaching provides on-the-job training and support to assist participants in stabilizing in a supported or self-employment situation. Intensive Job Coaching supports participants who require on-the-job support for more than 20% of their work week at the outset of the service, with the expectation that the need for support will diminish during the Intensive Job Coaching period (at which time, Extended Employment Supports will be provided if ongoing support is needed).

Intensive Job Coaching at the same employment site must be reauthorized after 6 months and may only be reauthorized twice, for a total of 18 consecutive months of Job Coaching support for the same position. A participant who needs Intensive Job Coaching at the same employment site for more than 18 consecutive months must request an exception to the limit consistent with
ODP policy.

Intensive Job Coaching may be reauthorized for the same location after a period of Extended Employment Supports, due to a change in circumstances (such as new job responsibilities, personal life changes, or a change of supervisor).

Extended Employment Supports are ongoing support available for an indefinite period as needed by the participant for 20% or less of their work week. Extended Employment Supports are available to support participants in maintaining their paid employment position or self-employment situation. This may include reminders of effective workplace practices and reinforcement of skills gained prior to employment or during the period of Intensive Job Coaching, coordinating with employers or employees and coworkers (including maintaining coworker supports). At least 1 visit per month to the participant at the work place is required in order to understand the current circumstances at the job site and to evaluate the participant's level of need for the Supported Employment service,

firsthand. This monthly monitoring will inform the employment supports provided by this service.

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

Intensive Job Coaching may be authorized every 6 months for a total of 18 consecutive months.

Extended Employment Supports may be authorized up to a maximum of 416 hours per year, with the year starting on the ISP authorization date.

Supported Employment services cannot be provided in facilities that are not a part of the general workplace.

Providers of Supported Employment services may not also be the employer of the participant to whom they provide Supported Employment.

Supported Employment does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the workplace.

The total combined hours for Community Support, Day Habilitation, Small Group Employment and Supported Employment services (Intensive Job Coaching, Direct and Extended Employment Supports, Direct) are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must request an exception to the limit consistent with ODP policy.

Supported Employment (when provided directly to the participant) may not be provided at the same time that quarter hourly-reimbursed Respite, Day Habilitation, Community Support, or Small Group Employment is provided.

Supported Employment services may not be rendered under the waiver until it has been verified that:
• The services are not available to the participant under a program funded by either the Rehabilitation Act of 1973, as amended by the Workforce Innovation and Opportunity Act of 2014, or the Individuals with Disabilities Education Act;
• The Office of Vocational Rehabilitation (OVR) has closed the participant's case or has stopped providing services to the participant;
• 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 or a participant has received an offer of competitive integrated employment prior to OVR making an eligibility determination, then OVR services are considered to not be available to the participant; or
• The participant is determined ineligible for OVR services.

A participant does not need to be referred to OVR if the participant is competitively employed and solely needs supported employment to maintain the participant's current job.

In the event that OVR closes the order of selection, the following process will be followed from the effective date until the closure is lifted:
• A participant who has been referred to OVR, but does not have an approved Individualized Plan for Employment (IPE) may receive Supported Employment.
• A participant who has not been referred to OVR may receive Supported Employment without a referral to OVR.

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 Supported Employment services; or
• Payments that are passed through to users of Supported Employment 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
Agency	Supported Employment Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Staff working directly with the participant must have one of the following by 7/1/2020 or within 6 months of hire if hired after 1/1/2020:

- Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE); or
- Have 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.

Effective 7/1/2020, newly hired staff who do not have the required certification when hired must work under the supervision of someone who is certified. This can occur for no longer than 6 months from the date of hire to allow the new hire time to obtain the certification.

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

The Supported Employment Agency must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of the Supported Employment service.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Individuals furnishing Supported Employment must:
• Be age 18 or older
• Have a high school diploma or equivalent
• If transporting participants, have a valid driver's license and automobile insurance.
• Complete required training developed by BSASP for Employment/Vocational Services regarding services for people with autism spectrum disorders.
• Complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Supports Coordination

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

Service Definition *(Scope):*

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

Supports Coordination involves the location, coordination, and monitoring of needed services and supports. The Supports Coordinator (SC) assists participants in obtaining and coordinating needed waiver and other State plan services, as well as housing, medical, social, vocational, and other community services, regardless of funding source.

The maximum caseload for a Supports Coordinator is 35 waiver participants, including participants in other Pennsylvania HCBS waivers, unless the requirement is waived by ODP in order to ensure a sufficient supply of Supports Coordinators in the waiver. A SC may not act as his or her own supervisor.

The service includes both the development of an Individual Support Plan (ISP) and ongoing supports coordination as follows:

1) Initial Plan Development:

The Supports Coordinator:
*Conducts assessments to inform service planning, including i) the Scales of Independent Behavior-Revised (SIB-R) to assess each participant's strengths and needs regarding independent living skills and adaptive behavior; ii) for participants living with family members, the Parental Stress Scale to evaluate the total stress a family caregiver feels based on the combination of the participants' and caregivers' characteristics; and iii) assessment information on the ISP form regarding the persons desired goals and health status. The Supports Coordinator completes the SIB-R and receives the Parental Stress Scale in advance of the initial ISP meeting. The assessment information on the ISP form is completed during the ISP team meeting described in Appendix D-1-d.
* Develops an initial ISP using a person centered planning approach to help the planning team develop a comprehensive ISP to meet the participant's identified needs in the least restrictive manner possible. The planning team includes the Supports Coordinator, the participant, and other individuals the participant chooses.
*The Supports Coordinator also ensures participant choice of services and providers by providing information to ensure participants make fully informed decisions.
*Initial Plan Development includes Supports Coordination to facilitate community transition for individuals who received Medicaid-funded institutional services (i.e., ICF/ID, ICF/ORC, nursing facility, and Institution for Mental Disease) and who lived in an institution for at least 90 consecutive days prior to their transition to the waiver. Supports Coordination activities for people leaving institutions must be coordinated with and must not duplicate institutional discharge planning.
* Assisting the participant and his or her representative with finding, arranging for, and obtaining services specified in an Individual Support Plan (ISP)
* Informs participants about and facilitates access to unpaid, informal, local, generic, and specialized non-waiver services and supports that may address the identified needs of the participant and help the participant achieve the goals specified in the ISP;
* Provides information to participants on the right to a fair hearing and assists with fair hearing requests when needed and upon request;
* Assists participants in gaining access to needed services;
* Assists participants in participating in civic duties.

2) Ongoing Supports Coordination:
Upon completion of the initial plan, the Supports Coordinator:
*Provides ongoing monitoring of the services included in the participant's ISP as described in Appendix D-2-a of the waiver. The Supports Coordinator must meet the participant in person no less than quarterly to ensure the participant's health and welfare, to review the participant's progress, to ensure that the ISP is being implemented as written, and to assess whether the team needs to revise the ISP. Within each year, at least one visit must occur in the participant's home. At least one visit must occur in a location outside the home where the participant receives services, if services are furnished outside the home. In addition, the Supports Coordinator must contact the participant, his or her guardian, or a representative designated by the participant in the ISP at least monthly, or more frequently as necessary to ensure the participant's health and welfare. These contacts may also be made in person. Monitoring the health and welfare of participants includes the review of information in health risk screening tools, when applicable, or whether there have been any changes in orders, plans or medical interventions prescribed or recommended by medical or behavioral professionals and whether those changes are being implemented.
*If the participant receives Behavioral Specialist Services, the Supports Coordinator ensures the participant's Behavioral Support Plan and Crisis Intervention Plan are consistent with the ISP, and reconvenes the planning team if necessary.

*Reconvenes the planning team to conduct a comprehensive review of the ISP at least annually or sooner if a participant's needs change or if a participant requests that the planning team be reconvened.
*Reviews participant progress on goals/objectives and initiates ISP team discussions or meetings when services are not achieving desired outcomes.
*The Supports Coordinator annually completes the SIB-R, the Parental Stress Scale, and the assessment information on the ISP form as part of the comprehensive review. The Supports Coordinator will use information from the assessments, as well as any additional assessments completed based on the unique needs of the participant, to revise the ISP to address all of the participant's needs.
* At the annual ISP meeting, the SC will provide the participant and his or her family with information on competitive integrated employment during the planning process and upon request;
*At least annually, and as needed, the Supports Coordinator assists the participant's physician, physician's assistant, or nurse practitioner in completing the Medical Evaluation form (MA-51) as necessary.
This includes helping the participant to schedule the appointment, helping the participant to arrange for transportation to the appointment, reviewing the completed form to ensure it is completed accurately, answering questions from the medical professional completing the medical evaluation, including the purpose of the form, and facilitating that the medical evaluation form is shared with the supports coordinator who keeps the original in the participant's file.
* Informs participants about and facilitates access to unpaid, informal, local, generic, and specialized non-waiver services and supports that may address the identified needs of the participant and help achieve the goals specified in the ISP
* Provides information to participants on the right to a fair hearing and assists with fair hearing requests when needed and upon request
*Assists participants in participating in civic duties.
*Coordinates ISP planning with providers of service to ensure there are no gaps in service or inconsistencies between services; coordinates with other entities, resources and programs as necessary to ensure all areas of the participant's needs are addressed; and contacts family, friends, and other community members as needed to facilitate coordination of the participant's natural support network
* Assists with resolving barriers to service delivery
* Keeps participants and others who are responsible for planning and implementation of non-waiver services included in the ISP informed of participant's progress and changes that may affect those services
* Responds to and assesses emergency situations and incidents and assures that appropriate actions are taken to protect the health and welfare of participants
*Arranges for modifications of services and service delivery, as necessary to address the needs of the participant, and modifies the ISP accordingly
*Works with ODP on the authorization of services on an ongoing basis and when ODP identifies issues with requested services
*Communicates the authorization status of services to ISP team members, as appropriate

The Supports Coordinator must ensure that the participant's initial and annual approved service plans are distributed to the participant, family, and ISP team members who do not have access to HCSIS within a timeframe established by ODP policy, or upon request.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania

Travel time may not be billed by the provider as a discrete unit of this service

If a participant refuses Supports Coordination services, ODP staff will perform the Supports Coordination tasks described in this waiver to assure health and welfare of the participant.

Supports Coordination Organizations must use HCSIS to maintain case records that document the following for all individuals receiving Supports Coordination:
1) The name of the individual.
2) The dates of the Supports Coordination services.
3) The name of the provider agency (if relevant) and the person providing the Supports Coordination.
4) The nature, content, units of the case management services received and whether goals specified in the ISP have been achieved.
5) Whether the individual has declined services included in the ISP.
6) The need for, and occurrences of, coordination with other Supports Coordinators or case managers.

7) A timeline for obtaining needed services.
8) A timeline for reevaluation of the ISP.

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

Support Coordination may not duplicate payments made to public agencies or private entities under the Medicaid State plan or other program authorities. A participant's Supports Coordination Organization may not provide any other waiver services for that individual. A Supports Coordination Organization which is enrolled as an Organized Healthcare Delivery System (OHCDS) may furnish Community Transition Services, Assistive Technology, Home Modifications, Transportation and Vehicle Modifications. A participant's Supports Coordination Organization may not have a fiduciary relationship with providers of the participant's other services, except for Community Transition Services, Assistive Technology, Home Modifications, Transportation and Vehicle Modifications. A participant's Supports Coordination Organization may not own or operate providers of Community Transition Services, Assistive Technology, Home Modifications, Transportation and Vehicle Modifications with which it is acting as an OHCDS.

Supports Coordination services to facilitate transition from an institution to the community are limited to services provided within 180 days of the person leaving the facility. Providers may not bill for this service until the date of the person's entry into the waiver program.

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	Supports Coordination Organization

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supports Coordination

Provider Category:
Agency
Provider Type:

Supports Coordination Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Individuals furnishing this service must:
•Have at least a Bachelor's degree in Education, Psychology, Social Work, or other related social sciences.
•Have either 1) at least three years' experience providing case management for people with disabilities or 2) at least three years' experience working with people with autism spectrum disorders
•If transporting participants, have a valid driver's license and automobile insurance.
•Complete required training developed by BSASP for AAW Supports Coordination for people with autism spectrum disorders.
•Complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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:

Therapies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling

Category 2: 11 Other Health and Therapeutic Services

Sub-Category 2: 11100 speech, hearing, and language therapy

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Therapies are services provided by health care professionals that enable individuals to increase or maintain their ability to perform activities of daily living. Therapies in this waiver are limited to:

1. Speech/language therapy provided by a licensed speech therapist or certified audiologist upon examination and recommendation by a certified or certification-eligible audiologist or a licensed speech therapist.
2. Counseling provided by a licensed psychologist, licensed psychiatrist, licensed social worker, licensed professional counselor, or licensed marriage and family therapist.

Therapy services are direct services provided to assist individuals in the acquisition, retention, or improvement of skills necessary for the individual to live and work in the community, and must be attached to an individualized outcome. The need for the service must be evaluated on a periodic basis, at least annually or more frequently as needed as part of the ISP process. This evaluation must review whether the individual continues to require the current level of authorized services and that the service continues to result in positive outcomes for the individual. It is recognized, however, that long-term Therapy services may be necessary due to an individual's extraordinary medical or behavioral conditions. The need for long-term Therapy services must be documented in the individuals ISP.

Therapies do not duplicate services under the State plan due to difference in scope, frequency and duration of services and to specific provider experience and training required to accommodate the individual's disability.

Travel time may not be billed by the provider as a discrete unit of this service.

The therapy services can be delivered in Pennsylvania and in states contiguous to Pennsylvania.

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

Medical Assistance, Medicare and private insurance-compensable services cannot be provided through the Medicaid Waiver unless these services are denied by the participant's health care plan(s). Therapies will be provided under the State Plan until the State Plan limitations have been reached.

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/Language Therapy

Provider Category	Provider Type Title
Agency	Speech/Language Therapy
Agency	Counseling
Individual	Counseling

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Therapies

Provider Category:
Individual
Provider Type:

Speech/Language Therapy

Provider Qualifications

License *(specify):*

Title 49, PA Code, Chapter 45

Certificate *(specify):*

Other Standard *(specify):*

Individuals providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker’s compensation insurance when required by Pennsylvania statute.

The provider standards in the Medicaid state plan will apply.

Individuals providing these services must complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Therapies

Provider Category:
Agency
Provider Type:

Speech/Language Therapy

Provider Qualifications

License *(specify):*

Title 49 PA Code, Chapter 45

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

The provider standards in the Medicaid state plan will apply.

Individuals providing these services must complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Therapies

Provider Category:

Agency

Provider Type:

Counseling

Provider Qualifications

License *(specify):*

Psychologist-Title 49 PA Code Chapter 41
Psychiatrist-Title 49 PA Code Chapter 17
Social Worker-Title 49 PA Code Chapter 47
Marriage and Family Therapist-Title 49 PA Code Chapter 48
Professional Counselor-Title 49 PA Code Chapter 49

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker’s compensation insurance when required by Pennsylvania statute.

The provider standards in the Medicaid state plan will apply.

Individuals providing these services must complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Therapies

Provider Category:

Individual

Provider Type:

Counseling

Provider Qualifications

License *(specify):*

Psychologist-Title 49 PA Code Chapter 41
Psychiatrist-Title 49 PA Code Chapter 17
Social Worker-Title 49 PA Code Chapter 47
Marriage and Family Therapist-Title 49 PA Code Chapter 48
Professional Counselor-Title 49 PA Code Chapter 49

Certificate *(specify):*

Other Standard *(specify):*

Individuals providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

The provider standards in the Medicaid state plan will apply.

Individuals providing these services must complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:

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

Service Definition *(Scope):*

An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is necessary to increase, maintain, or improve a participant's communication, self-help, self-direction, and adaptive capabilities. Assistive Technology also includes items necessary for life support and durable and non-durable medical equipment not available under the Medicaid state plan.

Assistive technology service includes activities that directly support a participant in the selection, acquisition, or use of an assistive technology device, limited to:
A. Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
B. Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
C. Coordination and use of necessary interventions or services with assistive technology devices, such as interventions or services associated with other services in the ISP;
D. Training or technical assistance for the participant, or, where appropriate, the participant's family members, guardian, advocate, authorized representative, or other informal support on how to use and/or care for the Assistive Technology;
E. Training or technical assistance for professionals or other individuals who provide services to the participant on how to use and/or care for the assistive technology;
F. Extended warranties;
G. Ancillary supplies and equipment necessary to the proper functioning of assistive technology devices, such as replacement batteries; and
H. Independent evaluation as required for this service, if not available through the State Plan, other waiver services, or private insurance.

All items shall meet the applicable standards of manufacture, design, and installation. If the participant receives Specialized Skill Development, Assistive Technology must be consistent with the participant's behavioral support plan, and crisis intervention plan, and/or systematic skill building plan.

Assistive technology devices costing $500 or more must be recommended by an independent evaluation of the participant's assistive technology needs, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant on the customary environment of the participant.

The independent evaluation must be conducted by a licensed physical therapist, occupational therapist, speech/language pathologist or a certified Assistive Technology professional as recognized by the Pennsylvania Initiative on Assistive Technology at the Institute on Disability at Temple University. The independent evaluator must be familiar with the specific type of technology being sought and may not be a related party to the Assistive Technology provider.

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

Maximum amount for this service is $10,000 over a participant's lifetime.

All items, pieces of equipment, or product systems must be used to meet a specific need of a participant. Items that are not of direct medical or remedial benefit to the participant are excluded. Items designed for general use are covered only if they meet a participant's needs and are for the exclusive use of, or on behalf of, the participant. Assistive technology services will not be provided through the waiver if they can be provided through the State Plan, Medicare and/or private insurance plans until any limitation has been reached and assistive technology services cannot duplicate items covered under the State 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	Service Agency
Agency	Durable Medical Equipment Suppliers
Agency	Independent Vendor

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:

Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of waiver services will have a signed Medical Assistance Provider Agreement, signed ODP Waiver Provider Agreement, and have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.
Providers that meet the standards for Supports Coordination or Specialized Skill Development may subcontract with providers of assistive technology as an Organized Health Care Delivery System as specified in Appendix I-3-g-ii.
Providers shall meet the applicable standards of manufacture, design, and installation for the items they provide under the waiver. Suppliers of medical equipment and supplies must meet the requirements for medical supplies providers specified in applicable State regulation.
Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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 Suppliers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Suppliers of medical equipment and supplies must meet the requirements for Medicaid State Plan medical supplies providers specified in 55 PA Code Chapter 1123.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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:

Independent Vendor

Provider Qualifications

License *(specify):*

Trade appropriate.

Certificate *(specify):*

Other Standard *(specify):*

Providers shall meet the applicable standards of manufacture, design, and installation for the items they provide under the waiver.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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 Planning

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03030 career planning

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

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

Service Definition *(Scope):*

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

The Career Planning service provides support to the participant to identify a career direction; develop a plan for achieving competitive, integrated employment at or above the minimum wage; and obtain a job placement in competitive employment or self-employment. If the participant receives Specialized Skill Development services, the Career Planning service must be consistent with the participant's Behavioral Support and Crisis Intervention Plans and/or Systematic Skill Building Plan. Career Planning may be provided concurrent with Supported Employment, Day Habilitation or Small Group Employment if the participant wants to obtain a better job or different job while continuing paid work.

Vocational Assessment and Job Finding.

1. Vocational Assessment
Vocational Assessment evaluates the participant's preferences, interests, skills, needs and abilities for the purpose of developing a Vocational Profile which is an inventory of actions, tasks or skill development that will position the participant to become competitively employed. The Vocational Profile also specifies restrictions as well as skills and needs of the participant that should be considered in the process of identifying an appropriate job placement, consistent with the participant's desired vocational outcome. It is specific to the participant and may be provided both directly to the participant and indirectly for the benefit of the participant.

Vocational Assessment includes:
• The discovery process, which includes but is not limited to identifying the participant's current preferences, interests, skills and abilities, including types of preferred and non-preferred work environments; ability to access transportation, with or without support; existing social capital (people who know the participant and are likely to be willing to help the participant) and natural supports which can be resources for employment. Discovery also includes review of the participant's work history.
• Community-based job try-outs or situational-vocational assessments.
• Identifying other experiential learning opportunities such as internships or short-term periods of employment consistent with the participant's skills and interests as appropriate for exploration, assessment and discovery.
• Facilitation of access to ancillary job-related programs such as Ticket to Work, including Ticket Outcome and Milestone payments, and work incentives programs, as appropriate.
• Facilitation of access to benefits counseling services provided by certified individuals.
• Development of a Vocational Profile that specifies recommendations regarding the participant's individual needs, preferences, abilities and the characteristics of an optimal work environment. The Vocational Profile must also specify the training or skill development necessary to achieve the participant's employment goals and which may be addressed by other related services in the participant's service plan.

Results of the Vocational Assessment service must be documented and incorporated into the participant's ISP and shared with members of the ISP team, as needed, to support the recommendations of the Vocational Assessment.

Travel time may not be billed by the provider as a discrete unit of this service.

Vocational Assessment can be delivered in Pennsylvania and in states contiguous to Pennsylvania.

2. Job Finding
Job Finding is an individualized, outcomes-based service that provides assistance to the participant in developing or securing competitive integrated employment that fits the participant's needs and preferences and the employer's needs. The Job Finding service is provided to support participants to live and work successfully in home and community-based settings, as specified by the ISP, and to enable the participant to integrate more fully into the community while ensuring the health, welfare and safety of the participant. It is specific to the participant and may be provided both directly to the participant and indirectly to the employer, supervisor, co-workers and others involved in the participant's employment or self-employment for the benefit of the participant.

If the participant has received Vocational Assessment services and has a current Vocational Profile, the Job Finding service will be based on information obtained and recommendations included in the Vocational Profile, as applicable. Documentation of consistency between Job Finding activities and the Vocational Profile, if applicable, is required.

Job Finding includes (as needed by the participant):
• Prospective employer relationship-building/networking;

• Identifying potential employment opportunities consistent with the participant's Vocational Profile;
• Collaboration and coordination with the participant's natural supports in identifying potential contacts and employment opportunities;
• Job search;
• Support for the participant to establish an entrepreneurial or self-employment business, including identifying potential business opportunities, development of a business plan and identification of necessary ongoing supports to operate the business;
• Identifying and developing customized employment positions including job carving;
• Informational interviews with employers;
• Referrals for interviews;
• Support of the participant to negotiate reasonable accommodations and supports necessary for the individual to perform the functions of a job.

Travel time may not be billed by the provider as a discrete unit of this service.

Job Finding may be delivered in Pennsylvania and in states contiguous to Pennsylvania.

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

Career Planning services may not be rendered under the waiver until it has been verified that the services are:
• Not available to the participant under a program funded by either the Rehabilitation Act of 1973, as amended by the Workforce Innovation and Opportunity Act of 2014, or the Individuals with Disabilities Education Act;
• The Office of Vocational Rehabilitation (OVR) has closed the participant's case or has stopped providing services to the participant;
• 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; or
• The participant is determined ineligible for OVR services.

A participant does not need to be referred to OVR if the participant is competitively employed and is seeking career planning services to find a new job, unless the purpose is job advancement which can be provided by OVR.

In the event that OVR closes the order of selection, the following process will be followed from the effective date until the closure is lifted:
• A participant who has been referred to OVR, but does not have an approved Individualized Plan for Employment (IPE) may receive Career Planning services.
• A participant who has not been referred to OVR may receive Career Planning services without a referral to OVR.

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 Planning services; or
• Payments that are passed through to users of Career Planning services.

Career Planning does not include supports that allow a participant to continue paid work once it is obtained.

Vocational Assessment is a time-limited service requiring re-authorization every 90 days and will be authorized for up to 1 year from initial authorization every time it is added to the ISP. Prior to the request for reauthorization, the ISP team will meet to clarify goals and expectations and review progress. ODP will review the reauthorization request and make a determination based on ODP policy. ODP may also recommend technical assistance to the provider or suggest the ISP team consider a change of provider.

Job Finding is a time-limited service requiring re-authorization every 90 days, and will be authorized for up to 1 year from initial authorization every time it is added to the ISP. Prior to the request for reauthorization, the ISP team will meet to clarify goals and expectations and review progress and the job finding strategy. ODP will review the reauthorization request and make a determination based on ODP policy. ODP may also recommend technical assistance to the provider or suggest the ISP team consider a change of provider.

Vocational Assessment may be authorized whenever the participant's circumstances or career goals change. Job Finding may be authorized if a placement ends or is determined unsatisfactory to the participant. As a part of determining if Job Finding should be reauthorized, ODP will consider the reasons that the placement did not work for the participant and what changes, if any, will need to be made in the type of placement or career choice.

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	Career Planning Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Career Planning

Provider Category:
Agency
Provider Type:

Career Planning Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Staff working directly with the participant must have one of the following by 7/1/2020 or within 6 months of hire if hired after 1/1/2020:
• Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE); or
• Have 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.

Effective 7/1/2020, newly hired staff who do not have the required certification when hired must work under the supervision of someone who is certified. This can occur for no longer than 6 months from the date of hire to allow the new hire time to obtain the certification.

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

The Career Planning Agency must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of the Career Planning service.

Individuals furnishing this service must:
-Have a high school diploma or equivalent; and

-Complete required training developed by the Bureau of Supports for Autism and Special Populations (BSASP) for Employment/Vocational Services for people with autism spectrum disorders,
-Complete standard ODP required orientation and annual training.

If transporting participants, have a valid driver's license and automobile insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institution to private residence where the person is directly responsible for his or her living expenses. Institutions include ICF/IID, ICF/ORC, nursing facilities, and psychiatric hospitals, including state hospitals, where the participant has resided for at least 90 consecutive days. Allowable expenses are those necessary to enable an individual to establish his or her basic living arrangement that do not constitute room and board. Community Transition Services are limited to the following:

- Essential furnishings and initial supplies (Examples: household products, dishes, chairs, and tables);
- Moving expenses;
- Security deposits or other such one-time payments 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: telephone, electricity, heating); and
- Personal and environmental health and welfare assurances (Examples: pest eradication, allergen control, one-time cleaning prior to occupancy.)

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense, or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Furnishings and supplies may be purchased in Pennsylvania and states contiguous to Pennsylvania.

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

Community Transition Services are limited to $4,000 in a participant's lifetime. This limitation generally would not impact participants' health and welfare. This service is only authorized for participants who move from institutional settings into the community. In the event that a participant would need community transition services beyond the above the limits in order to assure health and welfare, the Supports Coordinator based on appropriate documentation of need will convene an ISP meeting of the participant, and other team members to explore alternative resources to meet the participant's health and welfare as outlined in Appendix D.

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	Supports Coordination Organization
Individual	Independent Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

Supports Coordination Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.
After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.
Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.
Supports Coordination Organizations that meet the standards for the Supports Coordination Service may subcontract with providers of community transition services as an Organized Health Care Delivery System as specified in Appendix I-3-g-ii.
All individuals providing services must meet all local and state requirements for that 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:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Individual

Provider Type:

Independent Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.
After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.
Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.
All individuals providing services must meet all local and state requirements for that 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:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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:

Family Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**

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

Service Definition *(Scope):*

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

This service provides counseling and training for the participant's unpaid family and informal network to help develop and maintain healthy, stable relationships among all members of the participant's unpaid informal network, including family members, and the participant in order to support the participant in meeting the goals in the participant's ISP. Family Support assists the participant's unpaid family and informal care network with developing expertise so that they can help the participant acquire, retain or improve skills that directly improve the participant's ability to live independently. Emphasis is placed on the acquisition of coping skills, stress reduction, improved communication, and environmental adaptation by building upon family and informal care network strengths. The waiver may not pay for services for which a third party, such as the family members' health insurance, is liable.

The Family Support service does not pay for someone to attend an event or conference.

Family Support must be necessary to achieve the expected outcomes identified in the participant's ISP. The Family Support provider must update the Supports Coordinator at least monthly regarding progress toward the goals for the Family Support service. The Family Support provider must maintain monthly notes in the participant's file and have them available for review by ODP during monitoring. If the participant receives Specialized Skill Development/Behavioral Specialist Services, the Family Support provider must provide this service in a manner consistent with the participant's behavioral support plan and crisis intervention plan.

This service may be delivered in Pennsylvania and in states contiguous to Pennsylvania.

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

The Family Support Services may be authorized for a maximum of 40 hours per year, with the year starting on the ISP authorization date. This limitation generally would not impact participant's health and welfare. In the event that Family Support services would be needed beyond the above limits in order to assure health and welfare, based on the family's request or provider assessment that additional services would be needed, the Supports Coordinator will convene an ISP meeting of the participant, and other team members to explore alternative resources to assure the participant's health and welfare through other supports and services as outlined in Appendix D.

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	Family Support Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Support

Provider Category:

Agency

Provider Type:

Family Support Agency

Provider Qualifications

License *(specify):*

Psychologist-Title 49 PA Code Chapter 41
Social Worker-Title 49 PA Code Chapter 47
Marriage and Family Therapist-Title 49 PA Code Chapter 48
Professional Counselor-Title 49 PA Code Chapter 49
Professional Counseling Agency – Title 49 PA Code Chapter 49

Certificate *(specify):*

Other Standard *(specify):*

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

Have a Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Individuals within the agency furnishing this service must:
•Have one of the licenses described herein
•Complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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 Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

These are physical modifications to the primary private residence of the participant (including homes owned or leased by parents/relatives with whom the participant resides and life sharing homes that are privately owned, rented, or leased by the host family), which are necessary to ensure the health, security of, and accessibility for the participant and/or to enable the participant to function with greater independence in the home. These modifications must be outlined in the participant's ISP. If the participant receives Specialized Skill Development/Behavioral Specialist Services, modifications must be consistent with the participant's behavioral support plan and crisis intervention plan.

Home modifications must have utility primarily for the participant and be specific to the participant's needs. Home modifications that are solely for the benefit of the public at large, staff, significant others, or family members will not be approved. Home modification must be an item that is not part of general maintenance of the home, and be an item of modification that is not included in the payment for room and board. Home modifications include the cost of installation, repair, maintenance, and extended warranties for the modifications; and when necessary to comply with rental/lease agreements, return of the property to its original condition.

All modifications must meet the applicable standards of manufacture, design, and installation and comply with applicable building codes. Modifications not of direct medical or remedial benefit to the participant are excluded.

Modifications are limited to:
A. Alarms and motion detectors on doors, windows, and/or fences;
B. Brackets for appliances;
C. Locks;
D. Modifications needed to accommodate a participant's special sensitivity to sound, light or other environmental conditions,
E. Outdoor gates and fences;
F. Replacement of glass window panes with a shatterproof or break resistant material;
G. Raised or lowered electrical switches and sockets; and
H. Home adaptations for participants with physical limitations, such as ramps, grab-bars, widening of doorways, or modification of bathroom facilities.

This service may only be delivered in Pennsylvania.

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

This service is limited to no more than $20,000 per participant over a 10-year consecutive period in the same home. The period begins with the first use of the Home Modifications services. A new $20,000 limit can be applied when the participant moves to a new home or when the 10-year period expires. Exceptions to this limit may be considered based upon a needs assessment and require prior authorization by the ODP consistent with ODP policy.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).Building a new room is excluded. Home accessibility adaptations may not be used for the construction of a new home. Durable medical equipment is excluded.

Home Modifications may not be provided in homes owned, rented or leased by a provider agency. Home Modifications costing over $1,000 must be recommended by an independent evaluation of the participant's needs, including a functional evaluation of the impact of the modification on the participant's environment. This service does not include the independent evaluation. Depending on the type of modification, the evaluation may be conducted by an occupational therapist; a speech, hearing, and language therapist; a behavioral specialist; or another professional as approved in the ISP. The organization or professional providing the evaluation shall not be a related party to the Home Modifications provider.

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	Independent Vendor
Individual	Independent Vendors
Agency	Service Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Agency

Provider Type:

Independent Vendor

Provider Qualifications

License *(specify):*

Trade appropriate.

Certificate *(specify):*

Other Standard *(specify):*

Individuals providing this service shall meet all applicable state and local licensure requirements. All modifications shall meet applicable standards of manufacture, design, and installation.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Services shall be provided in accordance with applicable state and local building codes.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker’s compensation insurance when required by Pennsylvania statute.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

Independent Vendors

Provider Qualifications

License *(specify):*

Trade appropriate.

Certificate *(specify):*

Other Standard *(specify):*

Individuals providing this service shall meet all applicable state and local licensure requirements. All modifications shall meet applicable standards of manufacture, design, and installation.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Services shall be provided in accordance with applicable state and local building codes.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Agency

Provider Type:

Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Agencies that meet the standards for Supports Coordination or Community Support may subcontract with providers of Home Modifications as an Organized Health Care Delivery System as specified in Appendix I-3-g-ii.

Individuals providing this service shall meet all applicable state and local licensure requirements. All modifications shall meet applicable standards of manufacture, design, and installation.

Services shall be provided in accordance with applicable state and local building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not

specified in statute.

Service Title:

Nutritional Consultation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Nutritional Consultation provides assistance to participants with an identified food allergy, food sensitivity, or a serious nutritional deficiency, which can include inadequate food and overeating. Nutritional Consultation assists the participant and/or their families and 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. Telephone consultation is allowable a) if the driving distance between the provider and the participant is greater than 30 miles; b) if telephone consultation is provided according to a plan for nutritional consultation services based on an in-person assessment of the participant's nutritional needs; and c) if telephone consultation is indicated in the participant's ISP. If the participant receives Behavioral Specialist Services, the services delivered must be consistent with the participant's behavioral support plan and crisis intervention plan. This service does not include the purchase of food.

Travel time may not be billed by the provider as a discrete unit of this service.

This service may be delivered in Pennsylvania and in states contiguous to Pennsylvania.

Specify applicable (if any) limits on the amount, frequency, or duration 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
Individual	Dietician-Nutritionist
Agency	Dietician-Nutritionist 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:

Dietician-Nutritionist

Provider Qualifications

License *(specify):*

Title 49 PA Code Chapter 21, subchapter G

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

In addition to licensure, individuals furnishing this service must:

Complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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:

Dietician-Nutritionist Agency

Provider Qualifications

License *(specify):*

Title 49 PA Code Chapter 21, subchapter G

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

In addition to licensure, individuals furnishing this service must:

Complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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:

Small Group Employment

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03022 ongoing supported employment, group
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Small Group Employment services are direct services that provide community employment opportunities in which the participant is working alongside other people with disabilities. The intent of this service is to support individuals in transition to competitive integrated employment. Small Group Employment may not be provided in a facility subject to Title 55, Chapter 2380 or Chapter 2390 regulations. Small Group Employment does not include Supported Employment services. Participants must be paid at least minimum wage and the compensation must be similar to compensation earned by workers without disabilities performing the same work.

Small Group Employment options include: mobile work force, work station in industry, affirmative industry, and enclave. Small Group Employment services are only billable when the participant is receiving direct support during the time that he or she is working and receiving wages through one of these service options or during transportation to a work site.

A Mobile Work Force uses teams of individuals, supervised by a training/job supervisor, who conduct service activities away from an agency or facility. The provider agency contracts with an outside organization or business to perform maintenance, lawn care, janitorial services, or similar tasks and the individuals are paid by the provider.

A Work Station in Industry involves individual or group training of individuals at an industry site. Training is conducted by a provider training/job supervisor or by a representative of the industry, and is phased out as the individual(s) demonstrate job expertise and meet established work standards. A Work Station in Industry is an employment station arranged and supported by a provider within a community business or industry site, not within a licensed facility site. An example would be three seats on an assembly line within a computer chip assembly factory. The provider has a contract with the business to ensure that those three seats are filled by adults that they support.

Affirmative Industry is a business that sells products or services where at least 51% of the employees do not have a disability.

Enclave is a business model where participants are employed by a business/industry to perform specific job functions while working alongside workers without disabilities.

Small Group Employment includes supporting the participant with personal care needs that cannot, or would be inappropriate to, be provided with the support from coworkers or other natural supports.

The service includes transportation that is an integral component of the service, for example, transportation to a work site.

Small Group Employment must be necessary to achieve the expected outcomes identified in the participant's ISP. The Supports Coordinator must review this service at least quarterly, in conjunction with the participant, to assure that expected outcomes are met, to ensure the participant is aware of employment options, and to modify the ISP as necessary. The review must include an assessment of the participant's progress, identification of needs, and plans to address those needs. It is the participant's and services providers' responsibility to notify the Supports Coordinator of any changes in the employment activities and to provide the Supports Coordinator with copies of the referenced evaluation. The cost of transportation provided by staff to and from job sites is included in the rate paid to the program provider.

If the participant receives Specialized Skill Development services, this service includes implementation of the behavioral support plan (BSP), the crisis intervention plan (CIP) and/or the Systematic Skill Building plan (SBP). The service includes collecting and recording the data necessary to support review of the ISP, BSP and the SBP.

Effective 7/1/19, Small Group Employment may be provided without referring a participant to OVR as OVR does not provide Small Group Employment services.

Small Group Employment may not be provided at the same time that quarter hourly-reimbursed Respite, Day Habilitation, Community Support, or Supported Employment service (when provided directly to the participant) is provided.

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

Total combined hours for Specialized Skill Development/Community Support, Day Habilitation, Supported Employment (Intensive Job Coaching, Direct and Extended Employment Supports, Direct) and Small Group Employment are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must request an exception to the limit consistent with ODP policy.

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 Small Group Employment; or
• Payments that are passed through to users of Small Group Employment.

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	Small Group Employment Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Small Group Employment

Provider Category:
Agency
Provider Type:

Small Group Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Staff working directly with the participant to provide Small Group Employment services must have one of the following by 7/1/2020 or within 6 months of hire if hired after 1/1/2020:
• Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE); or
• Have 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.

Effective 7/1/2020, newly hired staff who do not have the required certification when hired must work under the supervision of someone who is certified. This can occur for no longer than 6 months from the date of hire to allow the new hire time to obtain the certification.

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

Individuals furnishing this service must:
•Be age 18 or older
•If transporting participants, have a valid driver's license and automobile insurance.
•Have a high school diploma or equivalent
•Complete standard ODP required orientation and annual training.

The Small Group Employment Agency must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of this service

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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:

Specialized Skill Development

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized Skill Development (SSD) is used to address challenges participants may have because of limited social skills, perseverative behaviors, rigid thinking, difficulty interpreting cues in the natural environment, limited communication skills, impaired sensory systems, or other reasons.

SSD uses specialized interventions to increase adaptive skills for greater independence, enhance community participation, increase self-sufficiency and replace or modify challenging behaviors. The intent of SSD is also to reduce the need for direct personal assistance by improving the participant's capacity to perform tasks independently.

Supports focus on positive behavior strategies that incorporate a proactive understanding of behavior and skill-building, not aversive or punishment strategies.

Services are based on individually-tailored plans developed by people with expertise in behavioral supports and independent living skills development.

Three levels of support include:
A. Behavioral Specialist services (BSS)
BSS provides specialized interventions that assist a participant to increase adaptive behaviors to replace or modify challenging behaviors of a disruptive or destructive nature that prevent or interfere with the participant's inclusion in home and family life or community life. The BSS promotes consistent implementation of the Behavioral Support Plan (BSP) and Crisis Intervention Plan (CIP) across environments and across people with regular contact with the participant, such as family, friends, neighbors and other providers. Consistency is essential to skill development and reduction of problematic behavior.

BSS includes both the development of an initial BSP and ongoing behavioral supports as follows:

1. BSS-Initial BSP Development:

The BSS Provider:
• Conducts a Functional Behavior Assessment (FBA) of behavior and its causes, and an analysis of assessment findings of the behavior(s) to be targeted so that an appropriate BSP may be designed;
• Develops an individualized, comprehensive BSP – a set of interventions to be used by people coming into contact with the participant to increase and improve the participant's adaptive behaviors–within 60 days of the start date of the BSS.
• Develops a CIP that will identify how crisis intervention support will be available to the participant, how the Supports Coordinator (SC) and other appropriate waiver service providers will be kept informed of the precursors of the participant's challenging behavior, and the procedures/interventions that are most effective to deescalate the challenging behaviors.
•Enters the BSP and the CIP into HCSIS.
•Upon completion of plan development, meets with the participant, family members, SC, other providers, and employers to explain the BSP and the CIP to ensure all parties understand the plans.
• The BSP justifies necessary levels of BSS. ODP reviews the amount of direct and consultative service requested before authorization to ensure it is appropriate given the needs identified.

2. BSS Ongoing Support: Ongoing support can occur both before and after the completion of the BSP. If the participant needs behavioral support before the BSP and CIP are developed, the SC may submit a request to ODP for ongoing support to be provided during plan development. Upon completion of the initial BSP, the Behavioral Specialist provides direct and consultative supports. This service may be furnished in a participant's home and at other community locations.

2a. BSS Ongoing-Direct supports include:
• Support of and consultation with the participant to help them understand the purpose, objectives, methods, and documentation of the BSP, evaluate the effectiveness of the BSP and review recommended revisions;
• Crisis intervention supports provided directly to the participant in response to a behavioral episode that manifests with acute symptoms of sufficient severity such that a prudent layperson could reasonably expect that the absence of immediate intervention will result in placing the participant and/or the persons around the participant in serious jeopardy including imminent risk of institutionalization or place the participant at imminent risk of incarceration or result in the imminent damage to valuable property by the participant.

2b. BSS Ongoing-Consultative supports include:
• Support of family members, friends, waiver providers, other support providers, and employers to help them understand the purpose, objectives, methods of implementation, and how progress of the BSP is collected and documented and to understand any revisions that have been made to the plan which have previously been agreed upon with the participant;
• Monitoring and analyzing data collected during the BSP implementation based on the goals of the BSP;
• If necessary, modification of the BSP or the CIP, possibly including a new FBA, based on data analysis of the plans implementation; and
• Crisis intervention supports provided to informal or formal caregivers in response to a behavioral episode that manifests with acute symptoms of sufficient severity such that a prudent layperson, could reasonably expect that the absence of immediate intervention will result in placing the participant and/or the persons around the participant in serious jeopardy including imminent risk of institutionalization or place the participant at imminent risk of incarceration or result in the imminent damage to valuable property by the participant.

The SSD provider must have a Behavioral Specialist available for crisis intervention support 24-hours a day, 7 days a week. The Behavioral Specialist on call for crisis response and the SC must have access to the participant's CIP.

The SC is responsible for ensuring that the participant's BSP and CIP are consistent with the participant's ISP, and will reconvene the planning team if there are any discrepancies. When a BSP or CIP is revised, the Behavioral Specialist must update the BSP and CIP in HCSIS and notify the participant and representative, if applicable, the SC, and all providers responsible for implementing the plan of the changes that were made to the BSP or CIP.

Travel time may not be billed by the provider as a discrete unit of this service.

B. Systematic Skill Building (SSB)
SSB uses evidence-based methods to help the participant acquire skills that promote independence and integration into the community, which are not behavioral in focus. While SSB develops a Skill Building Plan (SBP) based on the participant's goals, the person providing SSB is not the primary implementer of that Plan. People who provide other supports such as Community Support, Supported Employment, Day Habilitation or Residential Habilitation are primarily responsible for implementation of the SBP. Other people with regular contact with the participant—such as family, friends, neighbors and employers--may also implement the SBP to ensure consistent application of the approach determined most effective for that participant's skill acquisition. Aligning paid and natural supports in using the same SBP also promotes generalization of skills across different environments, often a challenge for individuals with ASD. Possible skills include how to cook or use public transportation.

1. SSB - SBP Development
The SSB Provider:
• Conducts an evaluation of the participant's abilities and learning style that is related to goals in the ISP. The evaluation may include the participant's history with skill acquisition as well as identification of the participant's baseline skills.
• Within 60 days of the start date of SSB, a SBP must be developed to address objectives that are aligned with the goals of SSB. The SBP should be informed by Applied Behavior Analysis and use techniques such as backward and forward chaining, prompting, fading, generalization and maintenance to develop adaptive skills and promote consistency of instructional methods across environments. The SBP includes benchmarks for assessing progress. A participant's SBP may address multiple skills, as appropriate to address different goals or objectives.
•The SBP justifies necessary levels of SSB services. ODP reviews the amount of direct and consultative service requested before authorization to ensure it is appropriate given the needs identified.

Upon completion of the initial SBP, meets with the participant, family, SC, and other providers to explain the SBP to ensure all parties understand the plan, how to implement it, how to collect necessary data for evaluating effectiveness, and the importance of its consistent application.

2. SSB Ongoing Support: Upon completion of the initial SBP, the SSB provider provides direct and consultative supports. This service may be furnished in a participant's home and at other community locations.

2a. SSB Ongoing-Direct supports include:
• Support of and consultation with the participant to help them understand the purpose, objectives, methods, and

documentation of the SBP and review recommended revisions;
• Direct interaction or observation of the participant to evaluate progress and the need to revise the SBP or its objectives.

2b. SSB Ongoing-Consultative supports include:
• Support of family members, friends, waiver providers, other support providers, and employers to help them understand the purpose, objectives, methods, and documentation of the SBP and to understand any revisions that have been made to the plan which have previously been agreed upon with the participant;
• Monitoring and analyzing data collected during implementation of the SBP based on the goals of the SBP;
• Modifying and revising the SBP.

Travel time may not be billed by the provider as a discrete unit of this service.

C. Community Support
Community Support assists participants in acquiring, retaining, and improving communication, socialization, self-direction, self-help, and other adaptive skills necessary to reside in the community. Community Support facilitates social interaction; use of natural supports and typical community services available to all people; and participation in education and volunteer activities.

Community Support includes activities that improve capacity to perform activities of daily living (i.e., bathing, dressing, eating, mobility, and using the toilet) and instrumental activities of daily living (i.e., communication, survival skills, cooking, housework, shopping, money management, time management, and use of transportation). Community Support may include personal assistance in completing activities of daily living and instrumental activities of daily living as an incidental component.

Community Support must be necessary to achieve the expected goals and objectives identified in the participant's ISP. It may include implementation of the BSP, the CIP and/or the SBP and collecting and recording the data necessary in order to evaluate progress and the need for revisions to the plan(s).

Community Support may be provided at three staffing levels, each with a different rate: one direct support professional (DSP) to one participant, one DSP to two participants and one DSP to three participants. The lower staffing level options should be used to allow flexibility in the level of support at times when two or three participants who share the same SSD/Community Support provider are engaged in the same activity. The staffing level is determined by the participant's need for support. One to one support is still available at those times when the participant's needs warrant it, or if the group activity is with participants using different providers. This service is provided primarily in private homes and in unlicensed, community-based settings.

Transporting participants may be billed by the provider as a discrete unit only when the participant is in the vehicle and the travel is integral to the delivery of the service.

2b. BSS Ongoing-Consultative supports include:
• Support of family members, friends, waiver providers, other support providers, and employers to help them understand the purpose, objectives, methods of implementation, and how progress of the BSP is collected and documented and to understand any revisions that have been made to the plan which have previously been agreed upon with the participant;
• Monitoring and analyzing data collected during the BSP implementation based on the goals of the BSP;
• If necessary, modification of the BSP or the CIP, possibly including a new FBA, based on data analysis of the plans implementation; and
• Crisis intervention supports provided to informal or formal caregivers in response to a behavioral episode that manifests with acute symptoms of sufficient severity such that a prudent layperson, could reasonably expect that the absence of immediate intervention will result in placing the participant and/or the persons around the participant in serious jeopardy including imminent risk of institutionalization or place the participant at imminent risk of incarceration or result in the imminent damage to valuable property by the participant.

The SSD provider must have a Behavioral Specialist available for crisis intervention support 24-hours a day, 7 days a week. The Behavioral Specialist on call for crisis response and the SC must have access to the participant's CIP.

The SC is responsible for ensuring that the participant's BSP and CIP are consistent with the participant's ISP, and will reconvene the planning team if there are any discrepancies. When a BSP or CIP is revised, the Behavioral Specialist must update the BSP and CIP in HCSIS and notify the participant and representative, if applicable, the SC, and all providers responsible for implementing the plan of the changes that were made to the BSP or CIP.

Travel time may not be billed by the provider as a discrete unit of this service.

B. Systematic Skill Building (SSB)
SSB uses evidence-based methods to help the participant acquire skills that promote independence and integration into the community, which are not behavioral in focus. While SSB develops a Skill Building Plan (SBP) based on the participant's goals, the person providing SSB is not the primary implementer of that Plan. People who provide other supports such as Community Support, Supported Employment, Day Habilitation or Residential Habilitation are primarily responsible for implementation of the SBP. Other people with regular contact with the participant—such as family, friends, neighbors and employers--may also implement the SBP to ensure consistent application of the approach determined most effective for that participant's skill acquisition. Aligning paid and natural supports in using the same SBP also promotes generalization of skills across different environments, often a challenge for individuals with ASD. Possible skills include how to cook or use public transportation.

1. SSB - SBP Development
The SSB Provider:
• Conducts an evaluation of the participant's abilities and learning style that is related to goals in the ISP. The evaluation may include the participant's history with skill acquisition as well as identification of the participant's baseline skills.
• Within 60 days of the start date of SSB, a SBP must be developed to address objectives that are aligned with the goals of SSB. The SBP should be informed by Applied Behavior Analysis and use techniques such as backward and forward chaining, prompting, fading, generalization and maintenance to develop adaptive skills and promote consistency of instructional methods across environments. The SBP includes benchmarks for assessing progress. A participant's SBP may address multiple skills, as appropriate to address different goals or objectives.
•The SBP justifies necessary levels of SSB services. ODP reviews the amount of direct and consultative service requested before authorization to ensure it is appropriate given the needs identified.

Upon completion of the initial SBP, meets with the participant, family, SC, and other providers to explain the SBP to ensure all parties understand the plan, how to implement it, how to collect necessary data for evaluating effectiveness, and the importance of its consistent application.

2. SSB Ongoing Support: Upon completion of the initial SBP, the SSB provider provides direct and consultative supports. This service may be furnished in a participant's home and at other community locations.

2a. SSB Ongoing-Direct supports include:
• Support of and consultation with the participant to help them understand the purpose, objectives, methods, and

documentation of the SBP and review recommended revisions;
• Direct interaction or observation of the participant to evaluate progress and the need to revise the SBP or its objectives.

2b. SSB Ongoing-Consultative supports include:
• Support of family members, friends, waiver providers, other support providers, and employers to help them understand the purpose, objectives, methods, and documentation of the SBP and to understand any revisions that have been made to the plan which have previously been agreed upon with the participant;
• Monitoring and analyzing data collected during implementation of the SBP based on the goals of the SBP;
• Modifying and revising the SBP.

Travel time may not be billed by the provider as a discrete unit of this service.

C. Community Support
Community Support assists participants in acquiring, retaining, and improving communication, socialization, self-direction, self-help, and other adaptive skills necessary to reside in the community. Community Support facilitates social interaction; use of natural supports and typical community services available to all people; and participation in education and volunteer activities.

Community Support includes activities that improve capacity to perform activities of daily living (i.e., bathing, dressing, eating, mobility, and using the toilet) and instrumental activities of daily living (i.e., communication, survival skills, cooking, housework, shopping, money management, time management, and use of transportation). Community Support may include personal assistance in completing activities of daily living and instrumental activities of daily living as an incidental component.

Community Support must be necessary to achieve the expected goals and objectives identified in the participant's ISP. It may include implementation of the BSP, the CIP and/or the SBP and collecting and recording the data necessary in order to evaluate progress and the need for revisions to the plan(s).

Community Support may be provided at three staffing levels, each with a different rate: one direct support professional (DSP) to one participant, one DSP to two participants and one DSP to three participants. The lower staffing level options should be used to allow flexibility in the level of support at times when two or three participants who share the same SSD/Community Support provider are engaged in the same activity. The staffing level is determined by the participant's need for support. One to one support is still available at those times when the participant's needs warrant it, or if the group activity is with participants using different providers. This service is provided primarily in private homes and in unlicensed, community-based settings.

Transporting participants may be billed by the provider as a discrete unit only when the participant is in the vehicle and the travel is integral to the delivery of the service.

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

Behavioral Specialist, Specialized Skill Building, and Community Support may be furnished in a participant's home and at other community locations, such as libraries or stores.

Total combined hours for Community Support, Day Habilitation, Supported Employment (Intensive Job Coaching, Direct and Extended Employment Supports, Direct) and Small Group Employment are limited to 50 hours in a calendar week. Exceptions to this limit may be considered based upon a needs assessment and require prior authorization by the BSASP consistent with ODP policy.

Community Support may not be provided at the same time that quarter hourly-reimbursed Respite, Day Habilitation, Small Group Employment, or Supported Employment services (when provided directly to the participant) are provided.

A participant who is receiving Residential Habilitation services in a Community Home where that participant is the only person receiving services in that home may not also receive Specialized Skill Development/Community Support on the same day the participant is receiving Residential Habilitation (Community Home) consistent with ODP policy.

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	Specialized Skill Development Services Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Skill Development

Provider Category:

Agency

Provider Type:

Specialized Skill Development Services Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Specialized Skill Development Agency must:
Have a signed Medical Assistance Provider Agreement;
Have a signed ODP Waiver Provider Agreement;
After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.
Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania;
Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Providers of Behavioral Specialist services must:
• Have a Pennsylvania Behavior Specialist License OR
A Master's Degree in Social Work, Psychology, Education, or Applied Behavior Analysis OR
A Master's Degree with 50% or more coursework in Applied Behavior Analysis OR
A Master's Degree in a human services field related to Social Work, Psychology or Education (and is housed in the institution's Department or School of Social Work, Psychology, or Education) with 33% or more coursework in Applied Behavior Analysis
•Complete training in conducting and using a Functional Behavioral Assessment (FBA) and in positive behavioral support. The training must be provided by either the BSASP or by an accredited college or university. If this training was not provided by the BSASP, ODP must review and approve the course description.
•Complete required training developed by BSASP for Specialized Skill Development (SSD): Behavioral Specialist Services for people with autism spectrum disorders.
•Complete standard ODP required orientation and annual training.
•If transporting a participant, have a valid driver's license and automobile insurance.

Providers of Systematic Skill Building must:
• Have at least a Bachelor's Degree in Social Work, Psychology, Education, or a human services field related to Social Work, Psychology or Education or at least a Bachelor's Degree in another field and 3 or more years' experience directly supporting individuals with ASD in the community;
•Complete required training developed by BSASP for SSD: Systematic Skill Building services for people with autism spectrum disorders.
•Complete standard ODP required orientation and annual training.
•If transporting participants, have a valid driver's license and automobile insurance.

Providers of Community Support must:
•Be at least 18 years old;
•If transporting participants, have a valid driver's license and automobile insurance.
•Have at least a high school degree or equivalent;
•Complete standard ODP required orientation and annual training.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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:

Temporary Supplemental Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Temporary Supplemental services provide additional staff in the short term when it has been determined that the participant's health and welfare is in jeopardy and needed supports and services cannot be provided without additional staff assistance. This service is intended for those unforeseen circumstances which trigger a need for a time limited increase in support.

This service is intended for circumstances such as unplanned stressful life events which increase a participant's risk of a crisis event (such as the recent loss of a family member), or to support a participant to return to baseline following a recent crisis event, which triggered a need for a time-limited increase in support.

Temporary Supplemental services staff support the family, informal support network and existing services providers in avoiding a participant's entering into crisis or in stabilizing a participant following a crisis. If the participant receives Behavioral Specialist Services, this service includes implementing the behavioral support plan. The need for Temporary Supplemental services will be determined by ODP based on information and documentation from the Supports Coordinator, the Behavioral Specialist (if the participant receives Behavioral Specialist services), clinicians involved in the participant's care and other members of the ISP team including the participant and family or representative.

ODP reviews the continued need for Temporary Supplemental services based on data and information received from the Supports Coordinator, Behavioral Specialist (if the participant receives Behavioral Specialist services), clinicians involved in the participant's care, the participant and other team members, including the family or representative, at least weekly. When it has been determined by the team members that the participant has been stabilized, the Temporary Supplemental services will cease.

This service may be furnished in a participant's home and at other community locations where the participant is receiving supports and services in order to assist the participant with avoiding entering in to a crisis status or transitioning from a crisis status and to assure health and welfare. If the participant receives Specialized Skill Building services, this service includes implementation of the behavioral support plan (BSP), the crisis intervention plan (CIP) and/or the Systematic Skill Building plan (SBP). This service includes collecting and recording the data necessary to support review of the Individual Support Plan (ISP), the BSP and the SBP.

A participant receiving Residential Habilitation in a Community Home (Chapter 6400) who needs additional staff support while receiving Residential Habilitation Services on an ongoing basis after Temporary Supplemental services are exhausted may request a change in the Residential Habilitation level.

Travel time may not be billed by the provider as a discrete unit of this service.

This service may be delivered in Pennsylvania and in states contiguous to Pennsylvania.

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

Services are limited to 540 hours in a twelve-month period beginning on the date this service was first authorized. This service is used in response to an urgent, temporary need, therefore, it would not typically be included in an ISP during annual renewal, but be added through the Critical Revision process as needed. Within 5 business days of the HCSIS alert indicating submission of the Critical Revision, ODP will complete the review of the Critical Revision.

If a participant is experiencing numerous events which require this service, the Supports Coordinator will explore the following to ensure health and welfare:
* Accessing additional natural supports (e.g., assistance of family or local community organizations);
* Seeking services through non-waiver resources such as State Plan services or local community agencies; or
* Accessing residential habilitation services.

In addition, the team and ODP will invoke the risk management procedures to determine if the participant's health and welfare can be assured by this waiver.

This service may be provided in 55 Pa. Code Chapter 6400 Community Homes that serve no more than four persons at any one time.

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	Life Sharing Home Provider
Agency	Specialized Skill Development Provider Agency
Agency	Day Habilitation Provider
Agency	Residential Habilitation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Temporary Supplemental Services

Provider Category:

Agency

Provider Type:

Life Sharing Home Provider

Provider Qualifications

License *(specify):*

Title 55 PA Code Chapter 6500

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Temporary Crisis agencies provider staff must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of this service.

Temporary Crisis services staff must:
•Be age 18 or older
•Have a high school diploma or equivalent
•Complete standard ODP required orientation and annual training.
•If transporting participants, have a valid driver's license and automobile insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Temporary Supplemental Services

Provider Category:

Agency

Provider Type:

Specialized Skill Development Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Temporary Crisis agencies must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of this service.

Temporary Crisis services staff must:
•Be age 18 or older
•Have a high school diploma or equivalent
•Complete standard ODP required orientation and annual training.
•If transporting participants, have a valid driver's license and automobile insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Temporary Supplemental Services

Provider Category:

Agency

Provider Type:

Day Habilitation Provider

Provider Qualifications

License *(specify):*

Title 55 PA Code Chapter 2380

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Temporary Crisis agencies must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of this service.

Temporary Crisis services staff must:
•Be age 18 or older
•Have a high school diploma or equivalent
•Complete standard ODP required orientation and annual training.
•If transporting participants, have a valid driver's license and automobile insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Temporary Supplemental Services

Provider Category:

Agency

Provider Type:

Residential Habilitation Provider

Provider Qualifications

License *(specify):*

Title 55 PA Code Chapter 6400

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Temporary Crisis agencies provider staff must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of this service.

Temporary Crisis services staff must:
•Be age 18 or older
•Have a high school diploma or equivalent
•Complete standard ODP required orientation and annual training.
•If transporting participants, have a valid driver's license and automobile insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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:

Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation

Category 2:	Sub-Category 2:

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

Service Definition *(Scope):*

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

Transportation is a direct service that enables participants to access services and activities specified in their approved service plan. This service does not include transportation that is an integral part of the provision of another discrete Waiver service.

The Transportation service consists of:

1. Public Transportation. Public transportation services are vendor services provided to or purchased for participants to enable them to gain access to services, activities in the community and resources as specified in their service plans. Public transportation may be purchased by an OHCDS when the public transportation vendor does not elect to enroll directly.

2. Transportation-Trip. This service is transportation provided to participants for which costs are determined on a per trip basis. A trip is defined as transportation from a participant's home, a waiver service, activity in the community or resource specified in the participant's service plan to a waiver service, activity in the community or resource specified in the participant's service plan or the participant's home. Transportation may be used to travel to and from a job that meets the definition of competitive integrated employment. Taking a participant to a destination and returning the participant to his/her home is considered two trips or two units of service. Trip distances are defined by ODP through the use of zones. Zones are defined as follows:

- Zone 1 - greater than 0 and up to 10 miles;
- Zone 2 - greater than 10 and up to 30 miles; and
- Zone 3 – greater than 30 miles.

Providers that transport more than 6 participants are required to have an aide in the vehicle. If a provider transports 6 or fewer participants, the provider has the discretion to determine if an aide is required. The determination must be based upon the needs of the participants, the provider's ability to ensure the health and welfare of participants and be consistent with ODP requirements for safe transportation.

Participants authorized to receive Transportation services may not receive the direct provision of the following services at the same time they are receiving Transportation: Day Habilitation, Supported Employment, Therapies, Career Planning, Family Support, Nutritional Consultation, Specialized Skill Development, and Small Group Employment.

Participants authorized to receive Residential Habilitation or Life Sharing services may only be authorized for Transportation services as a discrete service when the participant requires transportation to or from a job that meets the definition of competitive integrated employment.

Transportation services may not be substituted for the transportation services that a state is obligated to furnish under the requirements of 42 CFR § 431.53 regarding transportation to and from providers of Medical Assistance services.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania.

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

Expenditure for Transportation is limited to $4,500 per participant's service plan year.

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	Transportation Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Transportation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agencies must have Public Utility Commission (PUC) Certification, when required by state law or comparable certificate in contiguous states.

Other Standard *(specify):*

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.
2. Have a signed ODP Waiver Provider Agreement on file with ODP.
3. Complete standard ODP required orientation and annual training.
4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures. Public transportation providers are exempt from this requirement.
5. Have Commercial General Liability Insurance.
6. Have documentation that all vehicles used in the provision of Transportation services have automobile insurance.
7. Have documentation that all vehicles used in the provision of Transportation services have current State motor vehicle registration and inspection.
8. Have Workers' Compensation Insurance, in accordance with state law.
9. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.
10. Comply with Department standards related to provider qualifications.

Drivers and aides working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.
2. Have criminal history clearances per 35 P.S. § 10225.101 et seq. and 6 Pa. Code Chapter 15.
3. Have a valid driver's license if the operation of a vehicle is necessary to provide Transportation services.

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCDS for public Transportation and Transportation-Trip.
ODP or its Designee for all types of Transportation providers that enroll directly with the Department.

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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 waiver participant's primary 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 ISP, to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. 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
• Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications
• Modifications to a vehicle owned or leased by a provider

Vehicle Modifications cannot be used to purchase or lease vehicles for waiver recipients, 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 Vehicle Modifications. In order for this service to be used to fund modifications of a new or used vehicle, a clear breakdown of purchase price versus modifications is required.

Vehicle Modifications funded through the waiver are limited to the following modifications:
• Vehicular lifts
• Interior alterations to seats, head and leg rests, and belts
• Customized devices necessary for the participant to be transported safely in the community, including driver control devices
• Modifications needed to accommodate a participant's special sensitivity to sound, light or other environmental conditions
• Raising the roof or lowering the floor to accommodate wheelchairs
All Vehicle Modifications shall meet applicable standards of manufacture, design and installation.

This service may be delivered in Pennsylvania and in states contiguous to Pennsylvania.

When vehicle modifications are included in an ISP, the Supports Coordinator must collect three bids from providers for the necessary modification and provide the three bids to ODP for consideration during ODP's review of the ISP.

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

Vehicle Modifications services are limited to $10,000 per participant during a 5-year period. The5-year period begins with the first utilization of authorized Vehicle Modifications services.

A vehicle that is to be modified, must comply with all applicable State standards.

The vehicle that is modified may be owned by the participant, a family member with whom the participant lives, or a non-relative who provides primary support to the participant and is not a paid provider agency.

Vehicle Modification services may also be used to adapt a privately owned vehicle of a Life Sharing host when the vehicle is not owned by the Life Sharing Provider agency.

Vehicle Modifications costing over $500 must be recommended by an independent evaluation of the participant's needs, including a functional evaluation of the impact of the modification on the participant's needs. This service does not include the independent evaluation. Depending on the type of modification, the evaluation may be conducted by an occupational therapist; a physical therapist, a behavioral specialist, or another professional as approved in the ISP. The organization or professional providing the evaluation shall not be a related party to the Vehicle Modifications provider.

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	Independent Vendors
Individual	Independent Vendors
Agency	Service Agency

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:

Independent Vendors

Provider Qualifications

License *(specify):*

Trade appropriate.

Certificate *(specify):*

Other Standard *(specify):*

Individuals providing this service shall meet all applicable state and local licensure requirements. All modifications shall meet applicable standards of manufacture, design, and installation.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Services shall be provided in accordance with applicable state and local building codes.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Individual

Provider Type:

Independent Vendors

Provider Qualifications

License *(specify):*

Trade appropriate.

Certificate *(specify):*

Other Standard *(specify):*

Individuals providing this service shall meet all applicable state and local licensure requirements. All modifications shall meet applicable standards of manufacture, design, and installation.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Services shall be provided in accordance with applicable state and local codes.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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:

Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and an ODP Waiver Provider Agreement.

After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.

Agencies that meet the standards for Supports Coordination or Community Support may subcontract with providers of Vehicle Modifications as an Organized Health Care Delivery System as specified in Appendix I-3-g-ii.

Individuals providing this service shall meet all applicable state and local licensure requirements. All modifications shall meet applicable standards of manufacture, design, and installation.

Services shall be provided in accordance with applicable state and local building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.

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:

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):

Provider agencies are required to obtain criminal background checks prior to hiring for all staff that provide direct services to any waiver participant. To comply with this requirement, providers must obtain a report of criminal history record information from the Pennsylvania State Police for staff who have been a resident of the Commonwealth for at least two years. For staff who have been a resident of Pennsylvania for less than two years, or currently reside in another state, a report of Federal criminal history record information must be obtained from the Federal Bureau of Investigation (FBI). A copy of the report(s) received from the Pennsylvania State Police and/or the FBI must be maintained in the provider’s records for a minimum of five years. As part of the waiver program’s annual monitoring cycle, provider qualifications are reviewed. The review includes an examination of providers’ personnel records for all direct care staff working with the participants in the sample to assure that criminal history background checks were obtained in a timely manner and do not list any offenses that would exclude the staff from providing services to waiver participants. Excluded offenses are in accordance with the Department of Aging’s Older Adult Protective Services Act policy. The guidance for these policies can be found in 55 Pa. Code§ 51.20Criminal History Check; 55 Pa. Code § 6400.21Criminal History Record Check; and 55 Pa. Code § 6500.23Criminal History Record Check.

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):

Appendix C: Participant Services

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

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

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Residential Habilitation (Community Home)	
Residential Habilitation (Family Living Home)	
Personal Care Home	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in response to C-5

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Habilitation (Community Home)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Residential Habilitation	☒
Specialized Skill Development	☒
Career Planning	☐
Respite	☒
Community Transition Services	☐
Home Modifications	☐
Small Group Employment	☐
Nutritional Consultation	☐
Temporary Supplemental Services	☒
Supported Employment	☐
Day Habilitation	☐
Therapies	☐
Family Support	☐
Supports Coordination	☐

Waiver Service	Provided in Facility
Vehicle Modifications	☐
Assistive Technology	☐
Transportation	☐

Facility Capacity Limit:

Four (4) or fewer for res hab and temporary crisis services. Community Homes serving five or more individuals may provide respite.

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Habilitation (Family Living Home)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Residential Habilitation	☒

Waiver Service	Provided in Facility
Specialized Skill Development	☒
Career Planning	☐
Respite	☒
Community Transition Services	☐
Home Modifications	☐
Small Group Employment	☐
Nutritional Consultation	☐
Temporary Supplemental Services	☒
Supported Employment	☐
Day Habilitation	☐
Therapies	☐
Family Support	☐
Supports Coordination	☐
Vehicle Modifications	☐
Assistive Technology	☐
Transportation	☐

Facility Capacity Limit:

Limited to two participants per Family Home

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is

not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Personal Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Residential Habilitation	☐
Specialized Skill Development	☒
Career Planning	☐
Respite	☒
Community Transition Services	☐
Home Modifications	☐
Small Group Employment	☐
Nutritional Consultation	☐
Temporary Supplemental Services	☒
Supported Employment	☐
Day Habilitation	☐
Therapies	☐
Family Support	☐
Supports Coordination	☐
Vehicle Modifications	☐
Assistive Technology	☐
Transportation	☐

Facility Capacity Limit:

Capacity of 8 or fewer

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

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

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

☐ **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 defined as parents, children, stepparents, stepchildren, grandparents, grandchildren, brothers, sisters, half brothers, half sisters, aunts, uncles, nieces or nephews may provide Community Support and Respite as employees of a provider agency providing these services. Family members may provide Transportation-Trip through an OHCDS.

Any family member may provide the above services, except a person who lives with the participant may not provide respite. Legal guardians who are family members may provide the services listed above. Legal guardians who are not family members may not provide waiver services.

Services provided by family members must:
meet the definition of a service/support outlined in Appendix C-3;
be necessary to avoid institutionalization;
be a service/support that is specified in the ISP;
be provided by a person who meets the provider qualifications and training standards specified in the waiver for that service;
be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service;
NOT be performing an activity that the family would ordinarily perform or is responsible to perform.

The ISP documents that the above criteria are met whenever a family member provides the service.

A family member who is employed as a service provider through an agency must comply with the following:
The family member may not provide more than 40 hours of services in a seven-day period. Forty hours is the total amount regardless of the number of individuals the family member serves under the waiver;
The family member must maintain and submit time sheets to the agency provider and other required documentation for hours worked

Monitoring Requirements:
Providers are responsible for ensuring family members are paid only for services rendered and are not paid for more hours than authorized in the ISP. As part of the billing validation process for a sample of participants described in Appendix I-2-d, ODP monitors whether providers paid family members for more hours than authorized in the ISP when participants elect to use family members as paid service providers.

The Supports Coordinator is required to conduct quarterly in-person monitoring visits for all participants to monitor the participants health, safety, and welfare and to review that services are provided as specified in the ISP. These visits provide an opportunity for the Supports Coordinator to talk to the participant to assess whether services reflect the participants preferences. The Supports Coordinator also talks to non-family members who interact with the participant on a regular basis, who may be able to identify whether the participant appears dissatisfied.

○ **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:

ODP developed provider informational materials, which have been widely distributed to providers and provider associations and are available upon request. ODP presents regularly to provider organizations to increase awareness of the waiver and outreach to individual providers who are already serving consumers with a developmental disability (both adults and children). ODP has staff that specifically focuses on provider recruitment. They have increased provider enrollment by contacting providers and provider associations proactively, focusing on areas of greatest need. Information regarding provider qualifications and the provider enrollment process are available on the DHS Web site and providers interested in providing waiver services may contact ODP at any time with questions. Staff provide technical assistance to providers in preparing an enrollment application. If a provider applies, ODP staff determine whether the provider meets the provider qualification criteria outlined in this waiver. (Training required by ODP is available at no cost to the provider.) If the provider meets the criteria, ODP notifies the Office of Medical Assistance Programs, which executes a Medical Assistance Provider Agreement with the provider.

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:
Performance Measure QP1: Number and percent of providers who meet licensing requirements. Numerator = Number of providers who meet licensing requirements. Denominator = Number of providers requiring a license.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Documentation on file in BSASP/Office of Medical Assistance Programs (OMAP)

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

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure 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:
Performance Measure QP2: Number and percent of providers who meet age, education, experience, and criminal background check requirements per Appendix C prior to service delivery. Numerator = Number of providers who meet age, education, experience, and criminal background check requirements per Appendix C prior to service delivery. Denominator = Number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA&I Process

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

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 90%+/-10%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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:
Performance Measure QP3: Number and percent of providers who completed required training. Numerator = Number of providers who completed required training. Denominator = Number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA&I Process

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 = 90%+/-10%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

QP3 and QP4. ODP conducts full reviews through the ODP QA&I Process on a 3-year cycle for Supports Coordination Organizations (SCO) and providers.

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.

QP2 and QP3: Through the QA&I Process, ODP conducts full reviews of 100% of SCOs and providers on a 3-year cycle using the standardized monitoring tools developed by ODP. If the required age, education, experience, criminal background check and staff training requirements are not documented in the provider's records, ODP will notify the provider and the provider must locate missing documentation or ensure that requirements are met within 30 days. The remediation for this process will occur as outlined in the ODP established corrective action process.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix

C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☒ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

(a)The following services are subject to a combined limit of 50 hours per calendar week: Specialized Skill Development – Community Support, Day Habilitation, Supported Employment (Intensive Job Coaching, Direct and Extended Employment Supports, Direct), and Small Group Employment. (b) ODP estimated that most participants would be employed or use Day Habilitation for 30 hours per week or less and that participants would not want or need more than 50 hours per week of these services. Historical utilization patterns have confirmed that estimate. (c) The limit is not planned to be adjusted over the course of the waiver period. (d) A participant whose needs, including health and welfare needs, exceed 50 hours a week may request an exception to the limit. The exception request is submitted in writing to ODP by the participant's Supports Coordinator on behalf of the participant, on a form designated by ODP. (e) As outlined in the service definitions for the services subject to this limitation, the participant may request an exception to the limitation to safeguard meeting the participant's needs. (f) Participants are notified of the amount of the limit through posting of the waiver for public comment, through the Participant Handbook (which is given to each participant at time of enrollment and to all enrolled participants when the Participant Handbook is revised), and by the Supports Coordinator during the initial ISP process and annually thereafter.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR

441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

CMS requested that information regarding Home and Community-Based Settings be moved to the Main Module, Attachment 2: Home and Community-Based Settings Waiver Transition Plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Support Plan (ISP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social Worker**
  Specify qualifications:
- ☐ **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Supports Coordination Organizations may also provide Community Transition Services, Assistive Technology, Home Modifications, and Vehicle Modifications, and may subcontract with providers of these services as an Organized Health Care Delivery System as specified in Appendix I-3-g-ii. ODP continues to anticipate these services will be used by a small number of participants. The participant may choose any provider for these services, either directly enrolled or through any OHCDS, and is not limited to his or her Supports Coordination Organization. ODP requires the Supports Coordination Organization to provide a document signed by the participant or his or her representative stating their understanding of the choice of providers available to them. ODP also reviews all ISPs to ensure that the needs of the participant are being addressed and that providers other than Supports Coordination Organizations are not excluded from providing service.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The participant and representative (if applicable) drive the ISP process to the extent they choose and are able to do so. The Supports Coordinator will encourage meaningful participation of the participant and the participant's representative (if applicable) in the ISP process. In assisting the participant to understand the process and who participates in it, and to understand the options for services and service delivery, the Supports Coordinator supports the participant and representative (if applicable) in using tools to be effective in leading and meaningfully participating in the development of the ISP. These may include accommodations for cultural considerations.

The ISP must be understandable to the participant and the individuals supporting him or her. It must be written in plain language and in a manner that is accessible to the participant and the participant's representative (if applicable) and in a manner that is accessible to the participant and the participant's representative (if applicable) if the participant and the participant's representative (if applicable) are limited English proficient.

If the participant uses an alternate means of communication or if his or her primary language is not English, the information-gathering and ISP development process will utilize his or her primary means of communication, an interpreter, or someone who has a close enough relationship with the participant to accurately convey what the participant is communicating.

The ISP process includes the following:

(A) Selection of a Supports Coordination Organization
ODP offers the participant the choice of all enrolled Supports Coordination Organizations once the participant is determined eligible for the waiver and assists the participant with choosing a Supports Coordination Organization. The participant selects the Supports Coordination Organization and may request a particular Supports Coordinator. If the requested Supports Coordinator is not available, the participant may request another Supports Coordinator. However, there may be times when an agency may assign a Supports Coordinator if the requested Supports Coordinator is not available (e.g., serving the maximum number of participants) or if the participant has no preference. The participant may also change his or her provider of Supports Coordination services at any time.

If the participant refuses the Supports Coordination service, ODP staff provide Supports Coordination.

(B) Use of Person Centered Planning
A participant's Individual Support Plan (ISP) is developed using Person Centered-Planning principles to ensure that the participant's preferences, choices, strengths, needs and desired goals drive the design and implementation of the support plan. Person-Centered Planning identifies and organizes information that focuses on a participant's strengths, choices, and preferences. It involves bringing together people the participant chooses to have involved in the planning process. Person-centered planning assists the participant with exercising his or her rights to determine what services the participant needs and determine his or her future to the extent the participant is capable and willing to do so and supports personal growth.

Resources are available for participants through ODP's online training platform and the DHS web site which describe the service planning and delivery process, available services and providers, and rights and safeguards.

(C) Choosing Who Participates in the ISP Process.

The participant and representative (if applicable) with the support of the Supports Coordinator, determines who should be involved in the development of the ISP. The ISP team includes the participant, his or her legal representative, and other individuals the participant has selected, including providers, family members, friends or others who are familiar with the participant.

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 Supports Coordinator is responsible for developing the ISP in collaboration with the planning team. The participant and representative (if applicable) will lead the person-centered planning process with the support provided by the SC as described in Appendix D-1-c.

The initial ISP is developed when a participant enrolls in the waiver and is updated annually thereafter during the Annual Review Plan process. In addition, the ISP can be revised at any time if needed in response to changing needs, goals or choices of the participant. The Supports Coordinator is responsible for developing ISPs by performing the following activities in accordance with the specific requirements and timeframes established by ODP:

A supports coordinator shall complete the following activities when developing an initial ISP:

(1) Coordinate information gathering and assessment activities which include the administration of required assessments prior to the initial ISP meeting.
(2) Within 20 days of selection of the Supports Coordination Organization, collaborate with the participant and persons designated by the participant to determine a date, time and location for the initial ISP meeting that is convenient for the participant.
(3) Distribute invitations to ISP team members prior to the initial ISP meeting.
(4) Facilitate the ISP meeting.
(5) Obtain agreement with the ISP and signatures documenting agreement from the participant, persons designated by the participant, and providers responsible for the plan's implementation.
(6) Submit the ISP to ODP for approval and authorization within 45 calendar days of selection of a Supports Coordination Organization. This timeframe may be extended for circumstances beyond the Support Coordinator's control with prior approval from ODP.
(7) If ODP requests revisions of the ISP, resubmit the amended ISP for approval and authorization within 7 days of the date ODP requested that the ISP be revised.
(8) Distribute the ISP to the ISP team members, including the participant and representative (if applicable), who do not have access to HCSIS within 14 days of its approval and authorization, in a manner chosen by the team member.

The Supports Coordinator shall complete the following activities as needed during the comprehensive annual review of the ISP according to the following timelines:
(1) Coordinate information gathering and assessment activities which includes the administration of assessments
(2) Collaborate with the participant and persons designated by the participant to coordinate a date, time and location for the annual review ISP meeting that is convenient for the participant.
(3) Distribute invitations to ISP team members before the annual review ISP meeting.
(4) Facilitate the ISP meeting.
(5) Obtain signatures from the participant, persons designated by the participant, and providers responsible for the plan's implementation to document their agreement with the ISP.
(6) Submit the ISP to ODP for approval and authorization
(7) If ODP requests revision of the ISP, resubmit the amended ISP for approval and authorization
(8) Distribute the ISP to the ISP team members, including the participant and representative (if applicable), who do not have access to HCSIS, in a manner chosen by the team member.

The Supports Coordinator shall complete the following activities when an ISP needs to be revised at a time other than the annual review:
(1) Convene an ISP team meeting within 10 days of a crisis event or convene an ISP team meeting when there is a change in a participant's individual's needs.
(2) For all ISP updates that change the amount and frequency of a HCBS, the Supports Coordinator shall communicate with the participant, or reconvene the ISP team, to discuss needed changes and revise the ISP.

Qualified providers of services are responsible for the following ISP roles and functions:
* Cooperating with the Supports Coordinator when the Supports Coordinator needs up-to-date information on the participant's progress
*Signing the ISP within 7 calendar days of the Supports Coordinator's request for signature.
*Ensuring that all staff who works directly with the participant is familiar with the approved and authorized ISP.
*Implementing the services as provided for in the ISP.

ODP is responsible to review, approve, and authorize the ISP in HCSIS within 15 calendar days of submission of the ISP to ODP. Once the ISP is approved and authorized, ODP notifies the Supports Coordinator.

(B) The Types of Assessments That Are Conducted To Support The ISP Process, Including Securing Information About Participant Needs, Preferences And Goals, And Health Status

The Supports Coordinator uses the Scales of Independent Behavior-Revised (SIB-R) to assess each participant's strengths and needs regarding independent living skills and adaptive behavior. The SIB-R also identifies risk factors related to challenging behaviors, such as behavior harmful to self or others. The SIB-R takes approximately an hour to complete and is conducted face-to-face with the participant (and a proxy such as a family member if the individual cannot communicate verbally). The SIB-R is completed in advance of the initial ISP development, and at least annually thereafter.

The Supports Coordinator uses the Quality of Life Questionnaire (QoLQ) developed by Schalock et al. to measure whether the waiver is improving the participant's quality of life. This questionnaire is a face-to-face interview with the participant or proxy and is conducted at the same time as the SIB-R. It takes approximately 30 minutes to complete.

A third assessment is the Parental Stress Scale (PSS). The PSS evaluates the total stress a parent feels based on the combination of the participant's and parents' characteristics. The PSS is administered to a parent or close family member, e.g., a grandparent or aunt. It is not administered to a participant's spouse, partner or significant other. In circumstances where the participant does not reside with a parent or close family member, but remains in contact with a parent or close family member, the expectation is that the Supports Coordinator still attempt to obtain a completed PSS from the parent or close family member. The parent or close family member may complete the PSS without the assistance of the Supports Coordinator and gives the completed questionnaire to the Supports Coordinator. It takes approximately 30 minutes to complete. The PSS is completed in advance of the initial ISP development, and at least annually thereafter.

The ISP form, completed during the planning meeting and documented in HCSIS, is used to collect information about the participant's desired goals and the participant's health status to inform service planning.

The ISP form also includes identifying information about the participant and a summary of all the assessments, outcomes and actions needed for implementation of the ISP. Information gathered for purposes of completing the ISP includes information on the participant's physical development, communication styles, learning styles, educational background, social/emotional information, medical information(including any needs identified in a health risk screening tool when applicable), personality traits, environmental influences, interactions, preferences, relationships that impact the participant's quality of life, and an evaluation of the risks to the participant's health and welfare. The ISP also includes who will provide services, the frequency of services, who is responsible for implementing different aspects of the plan, how services will be monitored for consistency with the ISP, and how both waiver and non-waiver services will be coordinated. The ISP makes clear who is responsible for addressing the participant's other needs, including those related to accessing health care, behavioral support, financial support, and risk mitigation to prevent or reduce the likelihood of negative health and welfare events.

(c) How the participant is informed of the services that are available under the waiver

To ensure the participant is aware of all service options, ODP provides each participant a list of Adult Autism Waiver services with brief, easy-to-understand definitions for each service when the person is determined eligible for the Adult Autism Waiver. The service list is available at any time upon request and available on the Internet. Supports Coordinators are responsible for ensuring that participants are informed of all home and community-based services funded through the waiver.

Supports Coordinators are also responsible for informing and fully discussing with participants the right to choose among and between services and providers to support the participant's needs. Supports Coordinators assist the participant with linking with chosen providers. The ISP Signature Page documents that participants were informed of their choice of providers and services. To further ensure that the participant and planning team are aware of all provider options, ODP maintains an on-line Services and Supports directory that includes all provider agencies enrolled to provide Adult Autism Waiver services, their contact information, and services available from each agency. ODP updates the Services and Supports Directory on a regular basis to ensure participants have up-to-date information regarding available providers.

Participants may receive the full Services and Supports Directory at any time upon request.

The ISP team discusses whether a participant's particular need can be met through natural supports, family, friends, or medical professionals etc. or if the need requires the support of a paid waiver or non-waiver service.

A completed ISP outlines the means of achieving goals important to the participant by integrating natural supports and funded supports. The ISP addresses all needs that affect the participant's health and welfare, including services that, if absent, would put the participant at risk to be placed in an institutional setting.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences

A participant's ISP is developed using the concept of Person-Centered Planning. As such, the ISP addresses the full range of participant needs and identified goals, including those related to healthcare, employment and other issues important to the participant. The ISP identifies both waiver and non-waiver funded services needed to assist the participant in achieving the identified goals, as well as the frequency, duration and amount of services.

The standardized ISP format contains the following sections relevant to a participant's goals, needs, and preferences:
•Individual Preferences – Like And Admire, Know And Do, Desired Activities, Important To, What Makes Sense
•Medical – Medications/Supplements (And Treatments), Allergies, Health Evaluations, Medical Contacts, Medical History
•Health and welfare – General health and welfare Risks, Fire Safety, Traffic, Cooking/Appliance Use, Outdoor Appliances, Water Safety (Including Temperature Regulation), Safety Precautions, Knowledge Of Self-Identifying Information, Stranger Awareness, Meals/Eating, Supervision Of Care Needs, Health Care, Health Promotion
•Functional Information – Functional Level, Educational/Vocational, Employment, Understanding Communication, Other Non-Medical Evaluation
•Financial – Financial Information, Financial Management, Financial Resources
•Other non-waiver supports and services that are part of the participant's everyday life.

The Supports Coordinator and the planning team also use the information obtained from the SIB-R, QoLQ, and PSS assessments to identify a participant's needs.

ODP has developed standard Supports Coordination training and posted it on an online training platform web site that provides instruction for completing all assessments, assembling the planning team, facilitating the planning team to develop the ISP, monitoring ISP implementation, and changing the ISP when necessary. Completion of this training is required for all Adult Autism Waiver Supports Coordinators. The online training platform includes continuing education and technical assistance for SCs as necessary.

(e) How waiver and other services are coordinated

The SC is responsible for ensuring that there is coordination between services in the ISP, available MA State Plan services and other services for which the participant is eligible, including unfunded and informal supports.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan

The ISP identifies the services and supports that best support the participant to achieve his or her goals. For waiver services, the participant, along with the planning team, selects service providers to implement the waiver services in the plan. The participant and team also identify the duration and frequency of each of the services based on the individual's assessed needs. As stated above, the ISP also includes non-waiver services that meet the participant's needs. The ISP identifies responsible parties for providing these supports as well. All waiver service providers listed in participant's ISP are notified when an ISP is developed or updated, to ensure providers have the latest information regarding their responsibilities for the waiver participant.

Supports Coordinators are responsible for regularly communicating with the participant's other waiver service providers to monitor the provision of services. Supports Coordinators must contact waiver service providers and visit the participant in-person at least quarterly to monitor that services are being provided in the amount, duration and frequency specified in the ISP. Visits with the participant must occur both in the participant's home and in other settings where he

or she receives services.

(g) How and when the plan is updated, including when the participant's needs change

Supports Coordinators must update the ISP at least every twelve months. The Supports Coordinator performs the SIB-R, QoLQ and PSS assessments, and then reconvenes the planning team to update the ISP. The planning team reviews the outcomes, needs, and services in the ISP and changes the ISP accordingly.

The ISP also must be updated when the participant's needs change or when the participant requests a change in the ISP. Required monitoring of the participant conducted by the Supports Coordinator is intended to prompt the Supports Coordinator, the participant and other team members to examine and takes steps to ensure that the participant receives the appropriate quality, type, duration and frequency of services and benefits as described in the ISP and to help the team determine whether an update to the ISP is warranted.

The Supports Coordinator must be particularly aware of the need to change the ISP to assure the health and welfare of the participant. The need to change the ISP may be identified by the participant, the Supports Coordinator, another service provider, or another individual (not necessarily individuals on the planning team). The Supports Coordinator must also anticipate possible negative effects of exhausting services which have limitations in the amount and plan accordingly.

When the Supports Coordinator, the participant or other team members identify changes in needs or gaps between the ISP and assessed needs, the Supports Coordinator is required to document the change or gap and take appropriate actions to resolve, including consultation with the participant and convening the ISP team.

If an ISP update changes the amount or frequency of a service, the Supports Coordinator must reconvene the ISP planning team to discuss the needed changes and how to revise the ISP. A participant may also request a change in his or her ISP at any time. If an update make a change that does not affect the amount or frequency of a service, the SC is not required to convene an ISP meeting.

When a participant requests an update in his or her ISP, the Supports Coordinator is responsible for facilitating the required process.

(h) Interim Service Plan
An interim service plan may be used only when a participant is enrolled in the waiver using reserve capacity for adults with ASD who have experienced abuse, exploitation, abandonment, and/or neglect and who have a protective services plan developed pursuant to the Adult Protective Services Act that specifies a need for long-term support. The interim plan will allow waiver services to start immediately to prevent future abuse, exploitation, abandonment, and/or neglect. An interim plan can be used for no more than 45 days. It is used in order to initiate services quickly and in advance of the development of the full ISP. ODP staff will provide supports coordination and work with the participant and representative (if applicable), Adult Protective Services staff, and others identified by the participant to create the interim plan. ODP will use the same process as is used to develop a full ISPs except the SIB-R, QoL, and PSS assessments will not be completed and only those parts of the ISP that are needed to facilitate completion of a temporary plan to prevent abuse, exploitation, abandonment, and/or neglect will be completed.

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 assessments described in Appendix D-1-d identify several types of risk that can affect people with ASD, including:
-Unstable housing situations
-Challenging behaviors that can lead to a participant's hospitalization or incarceration
-Stress that impedes informal caregiver supports
-Physical and mental health risks
-Risk of abuse, neglect, and exploitation

The assessments specified in the service planning process described in Appendix D-1-d include questions to identify the level of these risks. The ISP planning team will identify risks based on the assessments and develop strategies to address the risks based on the participant's needs, strengths, and preferences. If a participant refuses to perform actions needed to ensure his or her health or welfare, such as going to routine medical or dental examinations or complying with recommended medical or dental treatment, the refusal and continued attempts to inform the individual about the significance of the need to take certain actions shall be documented in the individual's file or service notes in HCSIS. Assessment, identification of risk, and determining how to address risk during the ISP process occur during a participant's initial enrollment in to the waiver, during the development of the initial ISP, and at least annually thereafter as part of revising the ISP. The SC is responsible for ensuring that assessed risks are considered when determining the goals or objectives of the ISP. As part of ODP's review of each ISP, ODP reviews the assessments used in the planning development process. This review includes confirming that the planning team identified and addressed assessed risks. If ODP determines that identified risks are not sufficiently addressed in the ISP, the SC will be asked to provide additional information or revise the ISP.

Supports Coordinators must obtain updated information about the status of identified risks at least quarterly, and will include risk assessment as part of the Supports Coordinator's quarterly monitoring of a participant's supports. For risks that require more urgency, such as loss of a primary caregiver, suicidal ideation, or a risk of eviction from housing at a date certain, Supports Coordinators will be required to obtain more frequent updates to ensure risks are being addressed.

In addition to the ISP development process, risks are identified through other means, such as reported incidents as described in Appendix G-1; Supports Coordinator monitoring conducted according to Appendix D-2; Adult Protective Services reports; and through calls from participants, family members and informal supports, and providers to ODP staff with questions or concerns. When ODP is made aware of a risk, ODP informs the Supports Coordinator of the risk. The Supports Coordinator is responsible for working with the participant, informal supports, and other providers to learn more about the risk and address the risk. When urgent risks occur, ODP also will notify direct service providers such as Specialized Skills Development, Residential Habilitation, and Supported Employment providers so they can address the risk as quickly as possible. ODP will also coordinate with Adult Protective Services (APS) on APS cases, as needed, to ensure a coordinated response.

When a waiver participant resides in their own home or in a family member's home, the participant's ISP must identify how back-up support will be provided in emergency situations such as when a staffing absence would jeopardize the individual's health and welfare. Back-up plans are developed as part of the ISP development process and depending on the individual's circumstances could include a family member, friend, or neighbor being available to assist the individual with little to no advance notice.

ODP holds quarterly risk management meetings to discuss the status of individuals who are at risk and the response that is being implemented. If ODP determines that issues exist at a system level which may increase risk, ODP will identify and implement a system-level response.

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.

(a) Choosing a Supports Coordination Organization
ODP offers the participant the choice of all enrolled Supports Coordination Organizations once the participant is determined eligible for the waiver and assists the participant with choosing a Supports Coordination Organization. The participant selects the Supports Coordination Organization he or she would like to use and may request a particular Supports Coordinator. If the requested Supports Coordinator is not available, the participant may request another Supports Coordinator. However, there may be times when an agency may assign a Supports Coordinator if the requested Supports Coordinator is not available (e.g., serving the maximum number of participants) or if the participant has no preference. The offer of choice among any enrolled Supports Coordination Organizations is documented on the Supports Coordinator Choice Form. As with all services in the Waiver, the participant can appeal if he or she feels that he or she was not given a choice of Supports Coordination provider.

(b) Choosing other service providers
Supports Coordinators are responsible for informing and fully discussing with participants the right to choose among and between services and providers to support participants' needs. Supports Coordinators assist participants with linking with chosen providers. During development of the initial ISP, the Provider Choice Form is used to document that the participant was given choice among enrolled providers. During the annual reviews of the ISP, the ISP Signature Page documents that participants were informed of their choice of providers and services. To further ensure the participant and planning team are aware of all provider options, ODP maintains an on-line Services and Supports Directory that includes all provider agencies enrolled to provide Adult Autism Waiver services, their contact information, and services available from each agency. ODP updates the Services and Supports Directory on a real-time basis to ensure participants have up-to-date information regarding available providers. Participants may receive the full Services and Supports directory at any time upon request.

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):

After the ISP meeting, the Supports Coordinator enters the ISP in HCSIS and submits it to ODP for approval. ODP approves all ISPs within 15 days of the date the Supports Coordinator submits the ISP to ODP for approval.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

☐ **Medicaid agency**

☐ **Operating agency**

☒ **Case manager**

☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

(a) The entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare

Supports Coordinators monitor participant health and welfare and ISP implementation.

(b) The monitoring and follow-up method(s) that are used

The Supports Coordinator monitors the implementation of the participant's ISP by visiting the participant and communicating with other waiver service providers and the participant's informal supports. The Supports Coordinator uses a standardized monitoring form developed by ODP and enters the results of the monitoring into HCSIS. ODP also monitors the implementation of the ISP through the approval of and authorizations of the initial ISP and subsequent ISPs by observing if the ISPs are addressing the changing needs of the participant.

During this regular monitoring, the Supports Coordinator is responsible to:
1) Assess the extent to which the participant has access to and is receiving services according to his or her ISP. This includes monitoring that providers delivered the services at the frequency and duration identified in the ISP, and that the participant is accessing the non-waiver supports and health-related services as indicated in the ISP;
2) Evaluate whether the services furnished meet the participant's needs and help the participant become more independent;
3) Assess the effectiveness of back-up plans and determine if changes are necessary;
4) Remind participants that they have free choice of qualified providers;
5) Remind the participant, providers, and informal caregivers that they should contact the Supports Coordinator if they believe services are not being delivered as agreed upon at the most recent ISP meeting;
6) Review the participant's progress toward goals stated in the ISP;
7) Observe whether the participant feels healthy and not in pain or injured;
8) Interview the participant and others involved in the participant's services to identify any concerns regarding the participant's health and welfare, and
9) Inform ODP immediately when participant's health and welfare is in jeopardy.

If at any point the Supports Coordinator believes that a participant's health and welfare is in jeopardy, he or she must take immediate action to assure the person's safety. When a Supports Coordinator identifies a less serious issue, he or she must work with the participant, informal supports, and service providers to address the issue. Depending on the severity and scope of the issue, the Supports Coordinator may reconvene the planning team to address the issue.

The Supports Coordinator must document in HCSIS all of his or her communications and actions regarding the waiver participant. ODP uses HCSIS to monitor that Supports Coordinators are conducting required monitoring visits. ODP reviews a sample of Supports Coordinator records to assure Supports Coordinators are properly addressing any identified problems.

(c) The frequency with which monitoring is performed

The Supports Coordinator is required to visit the participant in person at least once each quarter or every three (3) months. Within each year;
•At least one visit must occur in the participant's home; and
•At least one visit must occur in a location outside the home where a participant receives services, if services are furnished outside the home.

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:*

Supports Coordination Organizations also may provide Community Transition Services, Assistive Technology, Home Modifications, and Vehicle Modifications and may subcontract with providers of these services as an Organized Health Care Delivery System (OHCDS) as specified in Appendix I-3-g-ii. ODP reviews all ISPs that utilize Community Transition Services, Assistive Technology, Home Modifications, and Vehicle Modifications. These services have historically been used by a small number of participants.

The participant may choose any provider for these services and is not limited to his or her Supports Coordination Organization. Participants document that they understand that they have a choices of providers available to them through a form that is provided by their Supports Coordinator. ODP also reviews the ISP and the monitoring by Supports Coordinators to ensure that the best interests of the participant are being addressed.

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:
Performance Measure SP1: Number and percent of participants who have all assessed needs and personal goals addressed in the service plan. Numerator = Number of participants who have all assessed needs and personal goals addressed in the service plan through waiver funded services or other funding sources or natural supports. Denominator = Number of participants reviewed.

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

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

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 90%+/-10%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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.

Performance Measure:
Performance Measure SP2: Number and percent of participants whose service plans are updated/revised at least annually. Numerator = Number of participants reviewed whose service plans are updated/revised at least annually. Denominator = Number of participants reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 90%+/-10%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver 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:
Performance Measure SP3: Number and percent of participants whose needs changed and whose service plans were revised accordingly. Numerator = Number of participants reviewed whose needs changed and whose service plans were revised accordingly. Denominator = number of participants reviewed whose needs changed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 90%+/-10%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Performance Measure SP4: Number and percent of participants whose services were delivered in the type, scope, amount, duration and frequency specified in the service plan. Numerator = Number of participants whose services were delivered in the type, scope, amount, duration and frequency specified in the service plan. Denominator = Number of participants reviewed.

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 90%+/-10%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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:
Performance Measure SP5: Number and percent of participants whose records document choice between and among waiver services and providers was offered to the participant/family. Numerator = Number of participants whose records document choice between and among waiver services and providers was offered to the participant/family. Denominator = Number of participants reviewed.

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

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 = 90%+/-10%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

For Performance Measures SP1, SP2, SP4, and SP5, ODP staff review a proportionate, representative random sample of waiver participant records annually.

For Performance Measure SP3, a subset of the proportionate, representative random sample of waiver records of participants whose needs changed is reviewed.

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.

SP1. Number and percent of participants who have all assessed needs and personal goals addressed in the service plan through waiver funded services or services funded through other funding sources or through natural supports. ODP reviews a sample of records to determine if participants have all assessed needs and personal goals addressed in their service plans through waiver funded services or services funded through other funding sources or through natural supports. If a participant's plan does not contain evidence that all assessed needs and personal goals have been reviewed and/or addressed by the participant and his/her team, ODP will work with the SCO to ensure that the service plan is revised to support the identified assessed needs and personal goals. The SCO will provide ODP with the service plan approval date that reflects the changes made to the service plan that correct the identified noncompliance. Remediation by the SCO is expected within 30 days of notification.

SP2. Number and percent of participants whose service plans are updated or revised at least annually. If there is no evidence in the record that the service plan was completed, approved, and services authorized by the Annual Review Update Date, ODP will work with the SCO to ensure the service plan is completed within 30 days of notification.

SP3. Number and percent of participants whose needs changed and whose service plans were revised accordingly. ODP reviews a sample of records to determine if service plans were revised when a change in need was identified that required a change in services. If the service plan is not revised, ODP will inform the Supports Coordinator (SC) that revisions to the service plan must be made. Remediation is expected to occur within 21 days of notification.

SP4. Number and percent of participants whose services and supports were delivered in the type, scope, amount, duration and frequency specified in the service plan. Using the sample of waiver participants, ODP reviews the individual monitoring tool completed by the SCO and claims for services delivered to ensure that services have been delivered in the type, scope, amount, duration and frequency specified in the service plan. If services were not delivered as specified in the participant's service plan, the SCO will provide documentation to ODP of the resolution. Resolution can include but is not limited to change in service provider, resumption of services at required frequency, team meetings, or changes in frequency and duration of a service. Remediation is expected to occur within 21 days of notification.

SP5. Number and percent of participants whose records document choice between and among waiver services and providers was offered to the participant/family. If there was no documentation that choice between and among services and providers was offered, ODP will direct the SC to follow-up with the individual and his or her family to provide the necessary information. The SC will use the service plan Signature Form to document that choice between and among services and service providers was offered as well as to document the date follow-up occurred. Remediation actions and submission of documentation to ODP should occur within 30 days of notification.

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*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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.

At enrollment, the participant will be provided with a handbook that includes an explanation of the right to fair hearing and the procedures to exercise that right. In addition, during the initial planning meeting, the Supports Coordinator reviews the right to fair hearing and procedures for requesting a fair hearing with the participant.
A participant will also have his or her right to request a fair hearing discussed annually during the annual plan review meeting or at any other time upon request. In addition a participant will be notified in writing that he or she has a right to a fair hearing when ODP takes one of the following actions:
a) An individual is determined ineligible for the Adult Autism Waiver; or
b) An applicant or participant is not given the choice between community and institutional services (i.e., between Home and Community Based Services through the Adult Autism Waiver and Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) or Intermediate Care Facility for Persons with Intellectual Disabilities(ICF-ID) services); or
c) A participant is denied the provider(s) of their choice; or
d) Actions are taken to deny new or additional services; or
e) Actions are taken to suspend, reduce, or terminate existing services to a participant; or
f) A person is placed on the interest list according to Appendix B-3-f.

If the participant's services are being reduced, suspended, or terminated, the participant will have 30 calendar days from the date of the notice to appeal the change. If the participant files an appeal within 10 calendar days of the date of the notice, the appealed Waiver service(s) are required to continue until a decision is rendered after the appeal hearing (55 Pa. Code § 275.4(a)(3)(v)(C)(I)).
The notice to the participant will include language on the timeframes for filing an appeal. The date of the postmark on the request for an appeal will be used to determine if the 10 day requirement for continuation of services was met by the participant and/or representative. If the participant appeals between 11 and 30 calendar days after the date of the notice, the reduction, suspension, or termination of services will be implemented while the appeal is pending.

If a participant files an appeal, the participant has the right to request an optional pre-hearing conference with ODP, as applicable (55 Pa. Code § 275.4(a)(3)(ii) [relating to Procedures]). The pre-hearing conference gives both parties the opportunity to discuss and attempt to resolve the matter prior to the hearing. Neither party is required to change its position. The pre-hearing conference does not replace or delay the fair hearing process.

ODP maintains documentation of notices of adverse actions and all fair hearing requests. The Department of Human Services, Bureau of Hearings and Appeals also maintains documentation of appeals and appeal decisions in accordance with 55 PA Code Chapter 275.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Office of Developmental Programs (ODP)

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).

ODP operates a general information line at 1-866-539-7689, has a general information e-mail address, and a mailing address, all of which are posted on the DHS web site that it uses to receive complaints. ODP provides this contact information for complaints in writing after a person has been determined eligible for the waiver. The notification also explains that the individual has the right to request a fair hearing if applicable according to Appendix F-1 and explains that the complaint is not a pre-requisite or a substitute for a fair hearing.

All complaints are logged into a database. Complaints may include the following topics:
•Service quality
•Service timeliness
•Other topics related to the waiver

After a complaint is properly documented, it is forwarded to the appropriate staff person at ODP for resolution and that resolution is entered into the database. ODP will resolve complaints within 30 calendar days and the participant will be notified in writing of the resolution.

ODP will complete quarterly reports of complaints and their resolution. This report will be shared with staff for review and to assure all follow-up work to resolve complaints has been done.

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).

ODP uses an electronic web-based reporting solution for incident reporting and management known as the Enterprise Incident Management (EIM) system. All provider entities and SCOs are considered reporting entities and use EIM to report incidents to ODP. The incident lifecycle contains an incident notification process (known as the first section submission), a formalized investigation if warranted, a final notification process (known as the final section submission), and an approval process (known as the closure of the incident). When an event occurs, or is alleged to have occurred, that is considered an incident per policy, the initial notification is made by the reporting entity (provider or SCO) by submitting the first section of the incident report to ODP within 24 hours of discovery or recognition. SCs receive an alert that an incident was filed for a participant receiving support coordination services through the SCO. This first section of the incident report includes a description of the event, incident categorization, as well as the action taken to ensure the health and safety of the participant. Once the first section is submitted, ODP will review the first section of the incident report to ensure that prompt action was taken to protect the participant's health, safety, and rights. If the actions taken are insufficient, ODP will contact the reporting entity and direct additional actions.

All incidents are investigated to rule out or identify instances of abuse, neglect, or exploitation. In addition, certain categories of incidents are required to be investigated by an ODP certified investigator. These include incidents of abuse, neglect, misuse of funds, death and rights violations. Misuse of funds and rights violations are considered exploitation.

Abuse is defined as an allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Abuse is reported on from the victim's perspective, not the person committing the abuse.

-Physical abuse. An intentional physical act by staff or other person which causes or may cause physical injury to an individual, such as striking or kicking, as well as applying noxious or potentially harmful substances or conditions to an individual.

-Psychological abuse. An act, other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

-Sexual abuse. An act or attempted acts such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Any sexual contact between a staff person and an individual is abuse.

-Verbal abuse. A verbalization that inflicts or may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

-Improper or unauthorized use of restraint. A restraint not approved in the individual support plan or one that is not a part of an agency's emergency restraint procedure is considered unauthorized. A restraint that is intentionally applied incorrectly is considered an improper use of restraint.

Neglect is defined as the failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law or regulation. This includes the failure to provide needed care such as shelter, food, clothing, personal hygiene, medical care, protection from health and safety hazards, attention and supervision, including leaving individuals unattended and other basic treatment and necessities needed for development of physical, intellectual and emotional capacity and well-being. This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm.

Exploitation is defined to include misuse of funds and rights violation.
-Misuse of funds. An intentional act or course of conduct which results in the loss or misuse of an individual's money or personal property. Requiring an individual to pay for an item or service that is normally provided as part of the individual support plan is considered financial exploitation and is reportable as a misuse of funds. Requiring an individual to pay for items that are intended for use by several individuals is also considered financial exploitation. Individuals may voluntarily make joint purchases with other individuals of items that benefit the household.

-Rights violation. An act which is intended to improperly restrict or deny the human or civil rights of an individual, including those rights which are specifically mandated under applicable regulations. Examples include the unauthorized removal of personal property, refusal of access to the telephone, privacy violations and breach of confidentiality. This does not include restrictions that are imposed by court order or consistent with a waiver of licensing regulations.

As part of the investigation, an investigator must take his or her first witness statement within 24 hours of being assigned an investigation. The investigator must also complete all witness interviews within 10 days of being assigned the investigation. The investigation and a final investigation determination (either confirmed or not confirmed) must be completed within 30 days.

An incident report is considered finalized when the reporting entity submits the final section of the incident report to ODP. Where appropriate, the final section of the incident report will include the investigation determination as well as the corrective actions that were carried out or planned in order to mitigate and prevent the reoccurrence of the incident. All incident reports must be finalized within 30 days from the date of discovery or recognition or the incident report is not considered timely. If the reporting entity is unable to finalize the incident report within 30 days due to circumstances beyond its control, the reporting entity shall notify ODP that an extension is necessary and provide the reason for the extension. When the need for an extension is submitted, the reporting entity is obligated to adhere to the extension deadline otherwise the finalization of the incident report is not considered timely.

After the reporting entity finalizes an incident report, ODP performs a review of the incident report within 30 days from the date of finalization. This review ensures that the incident was managed effectively and according to policy and that the investigation determination is supported by evidence, corrective actions are appropriate, planned, and prevent reoccurrence, and other pertinent information is included as necessary.

In addition to reporting incidents to ODP, Pennsylvania also has protective service laws in place for adults with disabilities (ages 18-59) and older adults (ages 60 and over). All provider entities are mandated by law to report incidents of abuse, neglect, exploitation, and suspicious death to the appropriate protective services agencies.

Below is a listing of the types of incidents that require reporting within 24 hours of occurrence or discovery:

(1) Death.

(2) A physical act by an individual in an attempt to commit suicide.

(3) Inpatient admission to a hospital.

(4) Abuse, including abuse to an individual by another individual.

(5) Neglect.

(6) Exploitation.

(7) An individual who is missing for more than 24 hours or who could be in jeopardy if missing for any period of time.

(8) Law enforcement activity that occurred during the provision of an HCBS or for which an individual is the subject of a law enforcement investigation that may lead to criminal charges against the individual.

(9) Injury requiring treatment beyond first aid.

(10) Fire requiring the services of the fire department not including responses to false alarms.

(11) Emergency closure.

(12) A violation of individual rights.

(13) Theft or misuse of individual funds.

(14) Crisis Event.

The following types of incidents require reporting within 72 hours of occurrence or discovery:

(1) Use of a restraint.

(2) A medication error as specified in § 6100.466 (relating to medication errors), if the medication was ordered by a health care practitioner.

The following types of incidents require a formalized investigation to be completed by a Department-certified incident investigator:

(1) Death that occurs during the provision of a service.

(2) Inpatient admission to a hospital as a result of an accidental or unexplained injury or an injury caused by a staff person, another individual or during the use of a restraint.

(3) Abuse, including abuse to an individual by another individual.

(4) Neglect.

(5) Exploitation.

(6) An injury requiring treatment beyond first aid as a result of an accidental or unexplained injury or an injury caused by a staff person, another individual or during the use of a restraint.

(7) Theft or misuse of individual funds.

(8) A violation of individual rights.

If EIM is unavailable, providers must complete and e-mail incident reports using a password-protected Excel form developed by ODP. Providers must e-mail the password separately to protect participant confidentiality. The forms were designed to collect the exact data collected in EIM. In such cases, ODP staff will notify SCs of critical incidents for the participants they serve via telephone and/or e-mail of password protected files.

Individuals and/or entities that must report incidents

- Providers:

Employees, contracted agents and volunteers of Adult Autism Waiver providers are to respond to events that are defined as an incident. When an incident is recognized or discovered by a provider, prompt action is to be taken to protect the individual’s health, safety and rights. The responsibility for this protective action is assigned to the provider initial reporter and point person. The protection may include calling 911, escorting to medical care, separating the perpetrator, arranging for counseling and referring to a victim assistance program. Unless otherwise indicated in the individual support plan, the provider point person or designee is to inform the individual’s family or representative within 24 hours, or within 72 hours for medication errors, of the occurrence of an incident and to also inform the family or representative of the outcome of any investigation.

After taking all appropriate actions following an incident to protect the individual, the provider is to report all categories of incidents and complete an investigation as necessary whenever services or supports are:

1. Rendered at the provider's site;
2. Provided in a community environment, other than an individual’s home, while the individual is the responsibility of an employee, contracted agent or volunteer; or
3. Provided in an individual's own home or the home of his family, while an employee, contracted agent or volunteer is providing services in the home.

In addition, employees, contracted agents or volunteers of provider agencies are to report deaths, alleged abuse, or neglect when they become aware of such incidents regardless of where or when these incidents occur. If the death, alleged abuse or neglect occurred beyond the provider's responsibility as specified above (relating to providers) the provider is not to report the incident according to Appendix G-1-b, but instead should give notice of the incident to the individual's supports coordinator.

- Individuals and families.

Individuals and families are to notify the provider, when they feel it is appropriate, or their supports coordinator regarding any health and safety concerns they may have related to a service or support that they are receiving. If an individual or family member observes or suspects abuse, neglect or any inappropriate conduct, whether occurring in the home or out of the home, they should contact the provider or their supports coordinator, or both and they may also contact ODP directly at a toll-free number, 1-866-539-7689. The supports coordinator will either inform the involved provider of the incident or file an incident report. Once informed by the supports coordinator, the provider is subsequently responsible to take prompt action to protect the individual, complete an investigation as necessary and file an incident report. In the event of the death of an individual, the family is requested to notify the supports coordinator.

- Supports Coordinators

The supports coordinator is to immediately notify the provider when an individual or family informs their supports coordinator that an event has occurred that can be defined as an incident and services or supports were:

1. Rendered at the provider's site;
2. Provided in a community environment, other than an individual's home, while the individual is the responsibility of an employee, contracted agent or volunteer; or
3. Provided in an individual's own home or the home of his family, while an employee, contracted agent or volunteer is providing services in the home.

The provider is responsible for taking prompt action to protect the individual, completing an investigation as necessary and filing an incident report.

When an individual or a family member informs the supports coordinator of an event that can be categorized as an incident and the provider is not responsible for reporting the incident as specified in items 1 – 3 above, the supports coordinator will take prompt action to protect the individual. The supports coordinator may need to employ the resources of law enforcement, area agency on aging, counselors or other protective service agencies to protect the individual. Once the individual's health and safety are assured the supports coordinator will report the incident to ODP using the incident reporting methods described above. The supports coordination organization will assign a certified investigator if necessary according to Appendix G-1-d.

When the individual's supports coordinator is informed of the death of the individual, the supports coordinator will determine if a report has been filed by a provider. If a provider is not required to file the report, the supports coordinator will file an incident report.

If a supports coordinator is informed that a provider suspects that abuse or neglect is occurring beyond the authority of the provider to investigate as specified in items 1 – 3 above, the supports coordinator is to take all available action to protect the health and safety of the individual. The supports coordinator may need to employ the resources of law enforcement, area agency on aging, counselors or other protective service agencies to protect the individual. Once the individual's health and safety are assured the supports coordinator will report the incident to ODP using the incident reporting methods described above and the supports coordination organization will assign a certified investigator if necessary according to Appendix G-1-d.

- Office of Developmental Programs

In some circumstances, ODP staff may be required to report incidents. ODP staff are to report deaths and incidents of alleged abuse or neglect in circumstances when the process for reporting or investigating incidents, described in this waiver document, for providers or support coordination organizations compromises objectivity.

All providers must also comply with the notification requirements of 35 P.S. §§ 10225.101 -10225.5102 (Older Adults Protective Services Act) and 35 P.S. §§ 10210.101-10210.704 (Adult Protective Services Act).

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.

Supports Coordinators deliver and discuss information concerning protections from abuse, neglect, and exploitation, including how to notify appropriate authorities. Each waiver participant receives a document that includes contact information for Supports Coordinators, local authorities, family members, and advocacy organizations. Waiver participants, families, and/or legal representatives can use this information as needed to report concerns regarding abuse, neglect, and exploitation. This information is discussed at least annually or more frequently as determined necessary by the Supports Coordinator and at the request of a participant or caregiver.

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.

Entities that receive and evaluate reports:

ODP receives initial notification within the EIM system when the first section of the incident report is submitted by a provider or SCO. ODP evaluates all incident reports within 24 hours of their submission to ensure that:

• The provider took prompt action to protect the participant's health, safety and rights. This may include but is not limited to contacting emergency services such as 911, arranging medical care, separating the perpetrator and victim, arranging counseling or referring to a victim assistance program.

• When applicable, the provider met the mandatory reporting requirements by contacting the appropriate protective services agency for adults with a disability or older adults.

• The provider notified the family or guardian of the incident within 24 hours (unless otherwise indicated in the individual support plan).

• When applicable, the provider initiated an investigation by assigning the case to an ODP Certified Investigator (CI).

ODP requires separation of the victim from the alleged perpetrator (also known as the "target" of the investigation) when an allegation of abuse, neglect, or exploitation is made, and the individual's health and safety are jeopardized. Targets may not have contact with any participants registered to receive services until the investigation is concluded. This separation may include suspending or terminating the alleged target.

When a participant who is residing with his or her family experiences an incident that jeopardizes the victim's health and safety, the provider, SC or ODP will seek the assistance of law enforcement or Protective Service Agencies, who have the authority to remove the alleged perpetrator or the victim from the home or environment to ensure safety.

Incidents of abuse, neglect, misuse of funds, rights violation and death are investigated by persons that have completed the Department's approved certification course. CIs follow protocols established by ODP as part of the investigatory process. CIs accommodate the witness's communication needs as appropriate and conduct interviews individually, and in a private place, if possible. If the witness requires the presence of a third party, the CI must arrange for third party representation (i.e. a staff person or family member).

After the provider or SC submits the final section of the incident report, ODP staff perform a management review within 30 days and approve the report if:

• The appropriate action to protect the participant's health, safety and rights occurred;

• The incident was correctly categorized;

• Timely completion of the certified investigation occurred;

• The investigation summary supports the conclusion;

• Safeguards to prevent reoccurrence are in place;

• Corrective actions have occurred, or are planned to occur, in response to the incident to prevent reoccurrence. When corrective actions are planned the anticipated date of completion must be indicated;

• Changes were made in the participant's ISP necessitated by or in response to the incident;

• The participant or participant's family received notification of the findings by the reporting entity prior to the finalization of the incident report, unless otherwise indicated in the individual plan; and

• Incidents of abuse, neglect and exploitation were reported to the appropriate authority as required by Pennsylvania law.

ODP disapproves reports that fail to meet the criteria described above. Disapproved reports revert to the reporting entity, who corrects any deficiencies and resubmits the report for re-evaluation. ODP will continue to work with and monitor the

reporting entity to ensure appropriate adherence to the established policies. If the report is satisfactory, ODP closes the incident report.

If additional time is needed to finalize the report, the provider can have the deadline extended. Situations that may warrant an extension of time may include but are not limited to: discharge from hospital has not occurred, investigation is not complete due to law enforcement involvement or criminal justice activities, or witnesses are not able to be interviewed timely due to extenuating circumstances.

Supports Coordinators identify unreported incidents as they conduct monitoring of services and supports including documentation reviews. ODP identifies unreported incidents as part of the waiver participant record review sample. When an unreported incident is identified, the reviewer communicates this finding immediately to the provider who is required to ensure that an incident report is filed and appropriate action is taken to mitigate the incident and ensure action is taken to prevent reoccurrence.

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.

ODP is responsible for the oversight of and response to critical incidents. If the provider is licensed, ODP notifies the licensing agency of the incident and coordinates response to the incident with the licensing agency. Interaction with licensing agency staff must be made within one working day of reviewing and evaluating the incident.

The EIM system supports incident management for ODP by allowing for the documentation and analysis of incident data. Data from EIM is used to support implementing quality improvement, risk management and incident management processes for all levels of the support and service system. Through a review of the data, ODP identifies factors that put participants at risk and facilitates the development of interventions and improvement activities to mitigate future risk or reoccurrence. Key data elements of the incident management system include:

• Evidence of prompt and appropriate action in response to incidents.
• Timely reporting of incidents.
• Investigation of incidents.
• Corrective action in response to incidents.

ODP staff meet quarterly to review aggregated incident report data, discuss trends, identify possible causes of trends, and specify next steps for reducing participants' risk of abuse, neglect, or exploitation.

Prior to each of their monthly contacts with participants, supports coordinators review EIM (or if EIM functionality is unavailable – records they maintain based on e-mail notification of incidents as described in Appendix G-1-b and G-1-d) for the status of participants' incident reports and to identify the need for any ISP changes to prevent re-occurrence of any incidents.

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:

◉ **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).

ODP is clear on its mission to eliminate restraints as a response to challenging behaviors. ODP articulated a policy to prevent restraint use in a provider manual for all providers and in a manual specifically for supports coordinators. In addition, providers licensed by DHS to serve people with intellectual disabilities must follow practices articulated in the licensing regulations related to restraints (55 Pa. Code Chapters 2380, 6400, and 6500).

ODP only permits physical restraints, defined as a manual method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely. Physical restraints may only be used in the case of an emergency to prevent an individual from immediate physical harm to himself or others. A physical restraint may not be used for more than 30 cumulative minutes within a 2-hour period.

Physical restraints may be used only as a last resort safety measure when the participant is in immediate danger of harming him or herself and/or others and less restrictive techniques and resources have been tried but failed. A physical restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for staffing or individual support.

The following restraints are prohibited:
• Seclusion, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving. Seclusion includes physically holding a door shut or using a foot pressure lock.
• Prone position physical restraints and any physical restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints or allows for a free fall to the floor.
• Aversive conditioning, defined as the application of startling, painful or noxious stimuli.
• Pressure point techniques, defined as the application of pain for the purpose of achieving compliance. A clinically-accepted bite release technique that is applied only as long as necessary to release the bite is not considered a pressure point technique.
• A chemical restraint, defined as a drug used for the specific and exclusive purpose of controlling acute, episodic behavior. A Pro Re Nata (PRN) order for controlling acute, episodic behavior is a chemical restraint.
• A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body, including a geriatric chair, bedrail that restricts the movement or function of the individual, helmet with fasteners, waist strap, head strap, restraint vest, camisole, restraining sheet, restraint board, handcuffs, anklets, wristlets, muffs and mitts with fasteners, chest restraint, and other similar devices. A mechanical restraint does not include the use of a seat belt during movement or transportation.

Physical restraints must be included in the service plan and must be approved by a human rights team prior to implementation. The service plan must be reviewed, and revised, if necessary, according to the time frame established by the human rights team, not to exceed 6 months.

The service plan with restrictive interventions, including physical restraints, must include:

(1) The specific behavior to be addressed.
(2) An assessment of the behavior including the suspected reason for the behavior.
(3) The outcome desired.
(4) Methods for facilitating positive behaviors such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, recognizing and treating physical and behavior health conditions, voluntary physical exercise, redirection, praise, modeling, conflict resolution, de-escalation and teaching skills.
(5) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.
(6) A target date to achieve the outcome.
(7) The amount of time the restrictive procedure may be applied.
(8) The name of the staff person responsible for monitoring and documenting progress with the individual plan.

Through review of the incident report and individual support plans, ODP monitors both the use of approved

physical restraints and the procedures used when or if such methods were employed. This process is also used to ensure that no providers have utilized the prohibited practices of seclusion or prone position restraint.

ODP detects unauthorized or misapplied physical restraints through the various oversight and monitoring processes. Physical restraints that do not follow ODP standards are reported as abuse.

According to ODP policy, a participant's physical condition must be evaluated throughout the physical restraint in order to minimize the potential of individual harm or injury. A participant is immediately released from a physical restraint when he or she no longer presents a danger to self or others. Support staff monitors the participant for signs of distress throughout the restraint process and for a period of time (up to 2 hours) following the application of a physical restraint.

All anticipated physical restraint usage must be reviewed with the individual's Primary Care Physician (PCP) to ensure that there are no potential negative health and safety impacts. For example, a PCP may not agree to allow a physical restraint to be used for an individual with osteoporosis due to the risk of a broken bone.

Methods for Detecting Unauthorized use of Restraints or Seclusion

As articulated in Appendix G-1, ODP defines the unauthorized use of physical restraints as a form of abuse and requires providers to report incidents of abuse within 24 hours of occurrence or discovery. The Provider Manual and Supports Coordinator Manual also define the types of unauthorized restraints so providers can detect and report these abuses. All incidents are reportable through EIM or – if EIM functionality is unavailable – via e-mail as described in Appendix G-1-b.

After any use of a restraint, the Supports Coordinator must meet with the participant and his or her planning team for a post-restraint debriefing to determine how future situations can be prevented. The Supports Coordinator records information from the debriefing sessions in HCSIS as part of his or her service notes. These discussions can be separate and distinct with the intended purpose of determining what could have been done differently to avoid the restraint. Any changes to the individual's plan shall be documented in the ISP.

During the monitoring visits described in Appendix D, the Supports Coordinator assesses the participant's health and welfare. If the participant or another individual informs the Supports Coordinator of an unreported use of restraint, the Supports Coordinator shall 1) take whatever immediate steps are necessary to ensure the participant's health and welfare, and 2) report the incident according to the policy in Appendix G-1.

Training

Staff that administer physical restraints must have specific training regarding the appropriate use and safe implementation, as well as de-escalation techniques/alternatives. This training must be completed within the past 12 months and focus on the proper procedures and specific techniques to follow, ethics of using physical restraints and alternative positive approaches. ODP validates implementation of staff training as part of provider monitoring.

ODP utilizes a person-centered planning model for all activities associated with provider training for authorized physical restraints. Training and education for administering a physical restraint is based on the unique needs of the individual as outlined in the service plan. ODP requires that staff associated with waiver services that may need to employ a physical restraint be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

Training should be ongoing for all staff and should focus on overall supports for improving an individual's quality of life while maintaining his or her health and welfare. Acknowledging that there are providers that continue to serve and support individuals in a restraint-free environment and provide extensive training for

their staff, the guidelines issued by ODP are to be viewed as minimal expectations to help support the person and create a structure that prevents restraint. All providers should have procedures in place that address how people are supported in emergency situations where an individual's health and welfare may be at risk.

Training curricula is directly related to the service plan that includes the use of physical restraints. Staff training must occur prior to rendering services to a participant and annually. Examples of the types of education and trainings include multiple nationally recognized intervention programs that focus on the use of least restrictive interventions, such as Safe Crisis Management Certification Training Program and Crisis Prevention Institute's techniques of Nonviolent Crisis Management.

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:

ODP is responsible for oversight of the use of restraints. ODP analyzes data on restraint and unauthorized restraint as part of the regular analysis of incident data described in Appendix G-1. ODP also will review Supports Coordinator notes and provider records for a sample of participants and interview those participants. The review and interviews include questions to identify appropriate and inappropriate use of restraint. ODP will require corrective action if necessary. ODP will review individual occurrences of the use of restraints within 24 hours of occurrence. ODP staff meet quarterly to review aggregated data, discuss trends, identify possible causes of trends and specify next steps for eliminating inappropriate use of restraints.

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:

◉ **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.

ODP encourages use of positive behavioral supports and discourages restrictive interventions. ODP articulated this policy in a provider manual for all providers and a manual specifically for supports coordinators. In addition, providers licensed by DHS to serve people with intellectual disabilities must follow practices articulated in the licensing regulations related to restraints and seclusion (55 Pa. Code Chapters 2380, 6400, and 6500).

Use of Alternative Methods Before Instituting Restrictive Interventions

Waiver service providers are to pursue alternative strategies to the use of restrictive interventions. If the person receives Specialized Skill Development Services, the participant's Behavioral Support Plan (BSP) and Crisis Intervention Plan (CIP) identifies specific interventions tailored to the individual that anticipate and de-escalate challenging behaviors before restrictive interventions are considered necessary.

A restrictive intervention is a practice that limits an individual's movement, activity or function; interferes with an individual's ability to acquire positive reinforcement; results in the loss of objects or activities that an individual values; or requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.

A restrictive intervention may not be used as retribution, for the convenience of the staff persons or family, as a substitute for the program or in a way that interferes with the individual's developmental program. For each incident requiring restrictive interventions:

• Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive interventions.
• A restrictive intervention may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.

The use of aversive conditioning, defined as the application, contingent upon the exhibition of challenging behavior, of startling, painful or noxious stimuli, is prohibited.

Providers who use restrictive interventions as part of their operating procedures must have a restrictive intervention review committee. Restrictive procedure plans must be developed and approved by a human rights team prior to implementation. The restrictive procedure plan must be reviewed, and revised, if necessary, according to the time frame established by the human rights team, not to exceed 6 months.

The service plan with restrictive interventions, including physical restraints, must include:

(1) The specific behavior to be addressed.
(2) An assessment of the behavior including the suspected reason for the behavior.
(3) The outcome desired.
(4) Methods for facilitating positive behaviors such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, recognizing and treating physical and behavior health conditions, voluntary physical exercise, redirection, praise, modeling, conflict resolution, de-escalation and teaching skills.
(5) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.
(6) A target date to achieve the outcome.
(7) The amount of time the restrictive procedure may be applied.
(8) The name of the staff person responsible for monitoring and documenting progress with the individual plan.

Permitted restrictive interventions include:

• Token economies or other reward and/or level systems as part of programming.

• Environmental restrictions.

• Limiting access to objects or items, such as limiting access to food for participants diagnosed with Prader Willi.

• Any requirement that a person is legally mandated to follow as part of probation or a court restriction that supersedes regulation or other ODP policy.

Prohibited restrictive interventions include:

• The use of aversive conditioning; defined as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful or noxious stimuli.

• Access to or the use of a participant's personal funds or property may not be used as reward or punishment. A participant's personal funds or property may not be used as payment for damages unless the participant consents to make restitution for the damages.

The restrictive intervention plan shall be implemented as written. Supports Coordinators and providers who developed the plan shall keep copies of the restrictive intervention plan in the individual's record. A record of each use of a restrictive intervention documenting the specific behavior addressed, methods of intervention used to address the behavior, the date and time the restrictive intervention was used, the specific procedures followed, the staff person who used the restrictive intervention, the duration of the restrictive intervention, the staff person who observed the individual if seclusion was used and the individual's condition during and following the removal of the restrictive intervention shall be kept in the individual's record.

ODP requires documentation of restrictive intervention usage as part of the progress notes completed by provider staff. ODP utilizes a person-centered planning model for all activities associated with provider training for authorized restrictive interventions. Training and education surrounding restrictive interventions are based on the unique needs of the individual as outlined in the restrictive intervention plan. The curriculum is based on the specific techniques outlined in the restrictive intervention plan. ODP requires that staff associated with waiver services that may need to employ a restrictive intervention be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

Training curricula is directly related to the service plan that includes the use of restrictive interventions. Staff training must occur prior to rendering services to a participant and annually.

Methods for Detecting Unauthorized use of Restrictive Interventions

During the monitoring visits described in Appendix D, the Supports Coordinator interviews the participant and others involved in the participant's services to identify any concerns regarding the participant's health and welfare. The Supports Coordinator reviews the provider's record for documentation of restrictive interventions. If restrictive interventions are documented or if the participant or another individual reports undocumented usage of restrictive interventions, the Supports Coordinator shall 1) take whatever immediate steps are necessary to ensure the participant's health and welfare, and 2) meet with the participant and his or her planning team to determine how to prevent the usage of restrictive interventions. The Supports Coordinator records information from the debriefing sessions in HCSIS as part of his or her service notes. Any changes to the individual's plan shall be documented in the ISP.

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:

ODP oversees the use of restrictive interventions through oversight monitoring activities. Restrictive intervention procedure plans are approved by a human rights team prior to the use of any restrictive intervention. The only exception to using a restrictive intervention without an approved plan is when the intervention is used for the first time during an emergency situation in order to protect the health and safety of a participant. Restrictive interventions that do not follow ODP guidelines are reported as an incident of a rights violation and investigated. As a result of the investigation and incident management process, strategies are developed to prevent reoccurrence. In addition, through the person-centered planning process, the team regularly meets to review and discuss progress, lack of progress, and any overuse of restrictive interventions.

As part of the Department's annual licensing inspection process for licensed settings, licensing staff reviews service plans to identify participants who have restrictive interventions in place and to verify that restrictive intervention procedure plan regulations have been met. Providers that frequently use restrictive interventions are provided technical assistance, training and other resources needed to decrease restrictive intervention usage.

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:

ODP prohibits seclusion as a type of restrictive intervention. ODP is responsible for detecting the unauthorized use of seclusion. ODP analyzes data on seclusion as part of the regular analysis of incident data described in Appendix G-1. ODP also will review Supports Coordinator notes and provider records for a sample of participants and interview those participants. The review and interviews include questions to identify unauthorized use of seclusion. ODP will require corrective action if necessary. ODP will review individual occurrences of the use of seclusion within 24 hours of occurrence.

The processes for remediation in cases of seclusion are the same as those for restraint as explained in Appendix G (2)(c):

When alleged seclusion has been identified, the usage is reported as an incident of a rights violation and investigated. As a result of the investigation and incident management process, strategies are developed to prevent reoccurrence.

○ **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.

Through the Office of Medical Assistance Programs (OMAP) oversight, Fee for Service (FFS) and Managed Care Organizations (MCO) complete Drug Utilization Reviews (DURs). Each participant's medications are reviewed at the time of refill or with the addition of a new medication. The DUR uses a standard pharmacy program to look for problems like therapeutic duplication, prescribed allergic medications, dosages over the recommended level, concurrent use of contraindicated medications, etc. The pharmacist contacts the prescribing practitioner if there are problems before filling the prescription. Medication regimens are recorded in the participant's ISP, and Supports Coordinators review medication records, including for behavior modifying medications, to assess that the medications specified in the ISP are current. In addition, medication errors are a reportable incident. As part of annual provider monitoring, ODP reviews a sample of individual records, including medications. ODP also reviews incident reports related to medication errors, along with other incidents data as specified in Appendix G-1. ODP has access to nurses who help with questions about medications and responses. ODP requires corrective action if necessary.

Second-line monitoring is completed by the provider agency and verified by the Department of Human Services, Bureau of Human Services Licensing (BHSL) for participants who live in licensed residential habilitation settings. 55 Pa. Code § 6400.163 and § 6500.133 require that if a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a review with documentation by a licensed physician at least every 3 months that includes the reason for prescribing the medication, the need to continue the medication and the necessary dosage. The BHSL inspects each provider agency annually however the frequency in which each individual location receives an inspection varies depending on the size of the agency. At a minimum, each individual site is inspected at least once every three years. If BHSL finds that the provider has not complied with this regulation, the provider is directed to develop a plan of correction and provide it to BHSL. If acceptable, BHSL verifies that the provider has implemented the plan of correction.

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.

As part of annual provider monitoring, ODP reviews a sample of individual records, including medications. ODP also reviews incident reports related to medication errors, along with other incidents data as specified in Appendix G-1. ODP has access to nurses who help with questions about medications and responses. ODP requires corrective action if necessary.

ODP will work with ODP licensing staff when providing oversight of medication management to providers licensed by ODP: Community Homes, Family Living Homes, and Adult Training Facilities. ODP's licensing staff review medication information when conducting standard annual licensing reviews. This includes looking at medication practices, logs, storage, etc. Licensing reviews bring problematic patterns about medication administration practices to a central level and then they are addressed either directly with a provider or incorporated into the medication administration training course. ODP will review licensing reviews as part of annual provider monitoring.

Through OMAP oversight, FFS and MCO complete Drug Utilization Reviews (DURs). Each participants medications are reviewed at the time of refill or with the addition of a new medication. The DUR reviews the medications both prospectively and retrospectively. Findings are communicated to healthcare practitioners either collectively thru Continued Medical Education or individually. In addition to the pharmacist contacting the prescribing practitioner, patterns of potentially harmful practices are communicated to the practitioner community via remittance advices and CME addressing the particular issue. Information about best practices and potentially harmful new drug information is communicated to the field via Drug Alerts. Direct consultation with a pharmacist with a specialty certification in psychiatric pharmacology occurs on an as needed basis.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State regulations for licensed Community Home and Day Habilitation providers allow for the administration of medication by unlicensed staff when trained using a standard Medication Administration course. Licensed Family Living Homes may administer medications if trained by the participants health care provider. Other providers may administer medications to the extent state law permits.

The current medication administration course for Community Home and Day Habilitation providers requires the review of medication administration logs for errors in documentation including matching the persons prescribed medications on the log to those available to be given. Observations of medication passes are required on an annual basis. Clinical nursing staff are 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 appear in the regulations and setting up and monitoring self administration programs are taught as part of the medication administration program.

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:

Medication errors are reported to ODP via an electronic database (EIM), which is accessible by the Supports Coordinator, and providers. If EIM functionality is unavailable, errors are reported to ODP via e-mail as described in Appendix G-1-b.

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

Providers report medication errors in EIM, including wrong person, wrong medication (wrong medication, extra dose, and discontinued medication), wrong dose, wrong route, wrong time, wrong form, wrong technique/method, and wrong position. If EIM is unavailable, errors are reported to ODP via e-mail as described in Appendix G-1-b.

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

Providers report medication errors in EIM, including wrong person, wrong medication (wrong medication, extra dose, and discontinued medication), wrong dose, wrong route, wrong time, wrong form, wrong technique/method, and wrong position. If EIM is unavailable, errors are reported to ODP via e-mail as described in Appendix G-1-b.

○ **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.

As part of annual provider monitoring, ODP reviews a sample of individual records, including medications. ODP also reviews incident reports related to medication errors, along with other incidents data as specified in Appendix G-1. ODP has access to nurses who help with questions about medications and responses.

Through the Office of Medical Assistance Programs (OMAP) oversight, Fee for Service (FFS) and Managed Care Organizations (MCO) complete Drug Utilization Reviews (DURs). Each participants medications are reviewed at the time of refill or with the addition of a new medication. The DUR uses a standard pharmacy program to look for problems like therapeutic duplication, prescribed allergic medications, dosages over the recommended level, concurrent use of contraindicated medications, etc. The pharmacist contacts the prescribing practitioner if there are problems before filling the prescription.

The DUR reviews the medication both prospectively and retrospectively. Findings are communicated to healthcare practitioners either collectively thru Continued Medical Education or individually. In addition to the pharmacist contacting the prescribing practitioner, patterns of potentially harmful practices are communicated to the practitioner community via remittance advices and CME addressing the particular issue. Information about best practices and potentially harmful new drug information is communicated to the field via Drug Alerts. Direct consultation with a pharmacist with a specialty certification in psychiatric pharmacology occurs on an as needed basis.

In addition, the licensure agency monitors medication regimens. For licensed Community Homes, Family Living Homes, and Day Habilitation facilities, ODPs licensing staff review medication information when conducting standard annual licensing reviews. This includes looking at medication practices, logs, storage, etc. Licensing reviews bring problematic patterns about medication administration practices to a central level and then they are addressed either directly with a provider or incorporated into the medication administration training course.

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 instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Performance Measure HW1: Number and percent of confirmed incidents of abuse, neglect, exploitation and unexplained death for which corrective action was taken.

Numerator = Number of confirmed incidents of abuse, neglect, exploitation and unexplained death for which corrective action was taken. Denominator = Number of confirmed incidents of abuse, neglect, exploitation and unexplained death.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Incident Management (EIM)

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Performance Measure HW2: Number and percent of participants who received information about how to identify and report abuse, neglect and exploitation. Numerator = Number of participants who received information about how to identify and report abuse, neglect and exploitation. Denominator = Number of participants reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 90%+/-10%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state 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:
Performance Measure HW3: Number and percent of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame. Numerator = Number of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame. Denominator = All critical incidents, by type of incident.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Incident Management (EIM)

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

Data Aggregation and Analysis:

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

Performance Measure:
Performance Measure HW4: Number and percent of confirmed incidents reported and reviewed at quarterly risk management meetings to determine any patterns related to participants or providers. Numerator = Number of confirmed incidents reported and reviewed to quarterly risk management meetings. Denominator = All confirmed incidents.

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

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The 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:
Performance Measure HW5: Number and percent of participants with restrictive interventions where proper procedures were followed. Numerator = Number of participants with restrictive interventions where proper procedures were followed. Denominator = Number of participants with a restrictive intervention plan reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Incident Management (EIM)

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Performance Measure HW6: Number and percent of participants whose identified healthcare needs are being addressed. Numerator = Number of participants whose identified healthcare needs are being addressed. Denominator = Number of participants reviewed.

Data Source (Select one):
Other

If 'Other' is selected, specify:

Participant Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 90%+/-10%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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.

HW2. Number and percent of participants who received information about reporting abuse, neglect, and exploitation. ODP reviews a sample of participant records to determine if participants/families have been provided information about reporting abuse, neglect, and exploitation. If there was no documentation that the information was provided, ODP will direct the SC to follow-up with the participant and his or her family to provide the necessary information. The SC will use the service plan Signature Form to document that information about reporting abuse, neglect, and exploitation was offered as well as to document the date follow-up occurred. Documentation of remediation actions is expected to be submitted to ODP by the SCO within 30 days of notification.

HW4. All confirmed incidents of abuse, neglect or exploitation are reported and reviewed at quarterly risk management meetings to identify patterns of recurrence or risk by participants or providers. When such patterns are identified, ODP will contact the SC, the participant, the provider(s) or other individuals as appropriate to determine necessary follow-up actions to reduce the risk of recurrence.

HW6. Number and percent of participants whose identified health care needs are being addressed. Using the sample of waiver participants, ODP reviews monitoring conducted by the participant's SC. The ODP standardized individual monitoring tool includes questions evaluating whether identified health care needs are addressed as specified in the service plan. In any instance where the SC identifies a concern regarding addressing identified health care needs, and the issue remains unresolved, ODP will work with the SCO to resolve the situation. Resolution can include but is not limited to resumption of services at the required frequency, additional assessment by the current service provider, pursuit of a second opinion/consultation from an alternate provider, changes in service provider, team meetings, or changes in service schedule. The SCO will provide documentation of the resolution to ODP. Remediation is expected to occur within 30 days of notification.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 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.

ODP selects for review a proportionate, representative, random sample of waiver participants, using a confidence level of 90% and margin of error of 10%. The results obtained reflect how the AAW system is performing and if it is responsive to the needs of the participants served. ODP trends, prioritizes and implements system improvements (i.e., design changes) prompted as a result of an analysis of the discovery and remediation information obtained across each of the waiver assurance areas.

ODP leads quarterly Quality Management meetings attended by the supervisors of each BSASP Regional Office. These meetings focus on reviewing aggregated provider and participant monitoring data, designing improvement projects to respond to identified needs, and tracking progress on completion and effectiveness of these projects.

Specific to assuring health and safety, ODP staff meet quarterly regarding risk management. The meetings include a representative from the BSASP Central Office, each BSASP Regional Office, and the BSASP clinical team. Before each meeting, ODP reviews monthly incident report data and the results of monitoring of Supports Coordinator notes for participants who have exhibited “very serious” or “extremely serious” challenging behaviors, or who have experienced a crisis event in the past quarter. ODP staff analyze the data from that quarter and previous quarters to identify statewide and regional trends by incident type, by participant, and by provider. During the meeting, staff discuss identified trends, identify possible causes, and specify next steps for reducing participants’ risk of abuse, neglect, or exploitation.

ODP assigns staff to implement quality improvements based on the scope of the design change and the expertise required. ODP involves additional stakeholders including AEs, providers, supports coordination organizations, individuals served and their families, and other State agencies based on the design change involved and specific input needed.

Recommendations for action are also identified by ODP’s Information Sharing and Advisory Committee (ISAC). The ISAC serves as ODP’s stakeholder quality council. ODP prioritizes opportunities for system improvements in conjunction with the ISAC, then disseminates these priorities to the field. Stakeholders representing their constituencies on the ISAC are expected to collaborate with ODP in the implementation, monitoring and evaluation of changes designed to achieve system improvements using a data-based approach.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

When system design changes are made, ODP specifies discovery activities and measures specific to the particular design change to evaluate the effect of the changes. ODP monitors these system design changes during quarterly Quality Management and risk management meetings and on an annual basis.

ODP produces an Annual Quality Assurance Report with a summary of findings and corrective action from its review of performance across each of the waiver assurance areas from a sample of waiver participants. The primary audience for this report is the public, including people with ASD, advocacy groups, and providers. The report is posted on the DHS Web site.

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

On an annual basis, considering input from Quality Management meetings and the ISAC, ODP's Executive Staff assesses program and operational performance as well as ODP's Quality Management Strategy (QMS). Results of this review may demonstrate a need to revise ODP's QMS, including changing priorities, using different approaches to ensure progress, modifying roles and responsibilities of key entities, and modifying data sources in order to retrieve the information needed for measurement.

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).*

The methods used to ensure the integrity of payments made for waiver services include:

(a) An annual fiscal year audit of state government, grantees and providers of services conducted in compliance with the requirements of the Single Audit Act of 1984, P.L. 98-502, and the Single Audit Act Amendments of 1996, P.L. 104-156.

(b) The Department of the Auditor General, an independent office, and the fiscal "watchdog" of Pennsylvania taxpayers conducts the annual state fiscal year, Commonwealth of Pennsylvania Single Audit. The Office of Management and Budget (OMB) Circular No. A-133 issued pursuant to the Single Audit Act as amended, sets forth standards for obtaining consistency and uniformity for the audit of States, local governments, and non-profit organizations expending Federal awards. Additionally, the A-133 Compliance Supplement based on the requirements of the 1996 Amendments and 1997 revisions to OMB Circular A-133 provides for the issuance of a compliance supplement to assist auditors in performing the required audits. The guidelines presented in the compliance supplement are the basis for the financial and compliance testing of waiver services.

(c) Recipients of Federal funds who are contracted directly through the State or are enrolled as Medical Assistance providers of service are audited annually in accordance with the Single Audit Act, as amended. Profit and non-profit providers of service are audited exclusively by contracting with CPA firms. The DHS releases an annual Single Audit Supplement publication to county government and CPA firms which provides compliance requirements specific to DHS programs, including waiver services. The waiver services are tested in accordance with both the compliance requirements set forth by the OMB Circular A-133 compliance supplement and by the DHS single audit supplement. These procedures are applicable to providers of service regardless of whether the provider is a public or a private organization.

(d) The purpose of the Single Audit Supplement is to fill four basic needs: 1) a reference manual detailing additional financial and compliance requirements pertaining to specific DHS programs operated by local governments and/or private agencies; 2) an audit requirement to be referenced when contracting for single audit services, providing the auditing entity with the assurance that the final report package will be acceptable to the DHS; 3) a vehicle for passing compliance requirements to a lower tier agency; 4) additional guidance to be used in conjunction with the Single Audit Act as amended; OMB Circular A-133; Government Auditing Standards (commonly known as the "Yellow Book") issued by the Comptroller General of the United States; OMB Federal Compliance Supplement; and audit and accounting guidance issued by the AICPA.

(e) If issues of fraud and abuse are suspected, DHS will refer such situations to the DHS, OMAP, Bureau of Program Integrity for review, investigation and necessary action.

(f) Providers are reviewed by ODP through the Quality Assessment and Improvement (QA&I) process on a 3-year cycle. ODP compares paid claims data to provider records such as time sheets and reports of services rendered for a random selection of claims from the previous fiscal year across all participants served. This review is described in the Performance Measure for Appendix I. This is a desk review comparing a provider's records to a report of paid claims from PROMISe, the state's Medicaid Management Information System. ODP reviews for consistency of day and time between the documentation and the claim as well as documentation supporting the number of units billed.

The providers identified in the monitoring sample each year will have claims reviewed for a 95% confidence interval with a 5% margin of error by randomly selecting claims from the previous fiscal year across all participants served.

o Process to review findings, establish priorities, and develop remediation and improvement strategies, including roles and responsibilities (in addition to the overall process described in the Overview):

If ODP staff suspect inappropriate billing based on its monitoring, ODP staff will review the provider history through HCSIS and PROMISe reports and complete an investigation which may include additional review of services rendered reports, time sheets, and claims to determine if inaccurate or inappropriate billings were submitted.

Depending upon the findings of the review, remediation may require:

o ODP monitoring and training of provider staff in documentation of services rendered;
o A time-limited monitoring by ODP or provider supervisor of weekly time sheets submitted by staff
o Suspension of new enrollment
o Termination of contract
o Requiring the provider to refund inappropriately billed amounts

In any of the above situations, if the findings result in suspected fraud or abuse, ODP will report the provider staff or individual staff person to the DHS, Office of Administration (OA) Bureau of Program Integrity (BPI) for appropriate investigation and legal action as necessary.

ODP conducts post-payment review of billing of all providers included in annual monitoring activities. Providers determined to be high or medium risk are referred to the Bureau of Financial Operations (BFO). For provider's determined low risk, ODP works with the provider to find the appropriate resolution to the issues found and remediate to avoid repetition in the future. The BFO accepts recommendations from the program offices for audit. These are usually providers that are not meeting the standards set forth within the PA Title 55 Regulations. The BFO will then conduct research on the party/program to be audited. Generally, audits are conducted on the entities recommended by the program offices. This is primarily based on the program office's suspicion or evidence of fraud and or abuse. The BFO conducts an independent risk analysis of the Home and Community Based Services program. The criteria used are the various attributes of claims submitted to DHS for PROMISe payments. These may be the number of claims submitted for a period, the total value of claims submitted for a period, procedure codes or time in program providing audit-identified services. Also, the BFO may identify an entity to be audited based on work conducted at other entities or government agencies.

Risk is categorized as high, moderate or low. Types of risk could be both known and/or unknown. Audits are usually selected based on known risks. Types of risks that factor into audit selection are:

- *Potential for fraud*
- *Compliance with laws, regulations, etc.*
- *Controls (internal and external)*
- *Provider size*
- *Volume and value of claims*
- *Complaints*
- *Documentation of service delivery*

o The type, method, and frequency of ODP post-payment reviews that ensure the adequacy and the integrity of payments:

The provider of Assistive Technology, Community Transition Services, Home Modifications or Vehicle Modifications, whether directly enrolled or as an OHCDS, submits an estimate of the cost of the item to ODP for review. ODP staff review the estimate to determine whether the amount is reasonable based on fair market pricing to the general public. If the cost is determined to be unallowable or unreasonable based on fair market pricing to the general public, the service will not be authorized. The provider will be asked to provide another estimate.

Prior to service authorization, ODP reviews an estimate for the cost of the service for unallowable costs such as the payment of the first month's rent for Community Transition Services. If the cost is determined to be unallowable or unreasonable, the service will not be authorized. The provider will be asked to provide another estimate.

If the estimate is approved, the Supports Coordinator enters the service and the approved cost into the Individual Support Plan (ISP) in HCSIS for authorization by ODP. Once the service has been rendered, the OHCDS or directly-enrolled provider bills PROMISe for the exact amount of the bill or invoice. The directly-enrolled provider or the OHCDS, as applicable, must retain all invoices related to the cost on file and available for review by ODP.

All waiver services are prior authorized through the ISP process: the initial ISP is reviewed and authorized, annual review plans are reviewed and authorized and Critical Revisions (occasional changes to goals or services during the plan year) are also reviewed and authorized.

Prioritization of Provider Audits and Surveillance and Utilization Review: The Supports Coordinator, during their required monthly visit/contact with the participant, asks questions about waiver services utilization.

ODP staff review service utilization as part of the annual plan review process for each participant to determine whether previously projected utilization is realistic or requires adjustment. In addition, the participant interview tool used annually for a random sample of participants includes questions related to frequency and duration of service provision for each service on the ISP, with the exception of Residential Habilitation.

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:
Performance Measure FA1: Number and percent of claims supported by documentation that services were delivered. Numerator = Number of claims supported by documentation that services were delivered. Denominator = Number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Participant Record and Provider Reimbursement Operations and Management System (PROMISe)

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

		+/- 5 Confidence level: 95%
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:

Performance Measure FA2: Number and percent of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans. Numerator=Number of claims paid for participants who

were eligible on the date the service was provided and where services were consistent with those in service plans. Denominator=Number of claims paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Provider Reimbursement Operations Management System (PROMISe)

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

Data Aggregation and Analysis:

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

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

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:
Performance Measure FA3: Number and percent of claims paid using rates developed according to the rate methodology in Appendix I-2-a. Numerator = Number of claims paid using rates developed according to the rate methodology in Appendix I-2-a. Denominator = Number of claims paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Provider Reimbursement Operations Management System (PROMISe)

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

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

Data Aggregation and Analysis:

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

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.*

FA1 -ODP reviews a representative, random sample of claims annually to determine if they are supported by adequate provider documentation to substantiate that services were delivered.

FA2 -The reimbursement logic built into Pennsylvania's Medicaid Management Information System (MMIS) ensures that waiver participants were eligible for services on the date the service was provided, and that services paid are authorized in the participant's approved service plan. A problem may be identified by a provider or providers, contractors, ODP staff, or Office of Medical Assistance Programs (OMAP). The ODP Claims Resolution Section monitors claims activity on a monthly basis to identify potential issues with the eligibility information, or services paid inconsistent with the services authorized in the service plan.

FA3 -The reimbursement logic built into Pennsylvania's MMIS ensures that providers are not paid more than the rate that is stored in the system. A problem may be identified by a provider or providers, contractors, ODP staff, or OMAP. The ODP Claims Resolution Section monitors claims activity on a monthly basis to identify potential issues with the reimbursement rate.

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.*

FA1 -Number and percent of claims that are supported by documentation that services were delivered. If ODP finds inadequate provider documentation to support a claim, depending on the nature of the issue, additional records will be selected for review by ODP and the Department may initiate an expanded review or audit. If indicated, ODP will conduct further claims review and remediation activities as appropriate. The provider will be requested to submit a corrective action plan (CAP) that will specify the remediation action taken. Remediation is expected to occur within 30 days of the CAP approval date. Remediation may include locating documentation to support that services rendered are consistent with claim submission, training, voiding (and/or recovering) payments, and the initiation of provider sanctions, if the situation warrants. Department sanctions may range from restricting the provider from serving additional participants to the termination of the agency's waiver program participation. Department staff will ensure that payments are adjusted where necessary and determine if the extent of the problem warrants further action.

FA2 -Number and percent of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans. If a problem is identified, outreach is conducted with the provider and appropriate corrective action is conducted in a timely manner. Providers are expected to correct payments for inappropriate claims within 30 days of notification or discovery.

Trends are monitored to identify systemic errors which are corrected in collaboration with the MMIS contractor if necessary and, with the contractor who supports HCSIS, if applicable. Remediation is expected within 30 days.

Eligibility information entered into the system incorrectly is corrected and the universe of paid claims that was processed using the incorrect information is identified. In the rare event that an overpayment is made, ODP will immediately notify the provider and credit any overpayment on the next PROMISe billing cycle. Thus, the Federal Medical Assistance Percentages (FMAP) amount charged via the MMIS system to CMS is rapidly corrected, generally within one month or less after an overpayment is discovered. If an underpayment is made, the provider is contacted to void and resubmit in order to obtain the increased rate.

FA3 -Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. If a problem is identified, outreach is conducted with the provider and appropriate corrective action is conducted in a timely manner. Providers are expected to correct payments for inappropriate claims within 30 days of notification or discovery.

Trends are monitored to identify systemic errors which are corrected in collaboration with the MMIS contractor if necessary and, with the contractor who supports HCSIS, if applicable. Remediation is expected within 30 days of notification or discovery.

Rates entered into the system incorrectly are corrected and the universe of paid claims that was processed using the incorrect information is identified. In the rare event that an overpayment is made, ODP will immediately notify the provider and credit any overpayment on the next PROMISe billing cycle. Thus, the FMAP amount charged via the MMIS system to CMS is rapidly corrected, generally within one month or less after an overpayment is discovered. If an underpayment is made, the provider is contacted to void and resubmit in order to obtain the increased rate.

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*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

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

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

Services in the Adult Autism Waiver are paid based on a Medical Assistance fee schedule or on invoice costs for vendor services.

Medical Assistance (MA) Fee Schedule:

MA fee schedule rates are developed using a market-based approach. This process includes a review of the service definitions and a determination of allowable cost components which reflect costs that are reasonable, necessary and related to the delivery of the service, as defined in Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (OMB Circular Uniform Guidance, December 26, 2014). ODP establishes the fee schedule rates to fund services at a level sufficient to ensure access, encourage provider participation and promote provider choice, while at the same time ensuring cost effectiveness and fiscal accountability. The fee schedule rates represent the maximum rates that ODP will pay for each service.

ODP develops rates for each of the MA fee schedule services using the following process. ODP:
- *Reviews wage data provided by the Bureau of Labor Statistics to develop service-specific wage rates based on the staffing requirements and roles and responsibilities of the worker. This component is the most significant portion of the total payment rate.*
- *Considers the expected expenses for the delivery of the services under the waiver for the following major allowable cost categories:*

- The support needs of the participants
- *Staff wages*
- *Staff-related expenses*
- *Productivity*
- *Occupancy*
- *Program expenses and administration-related expenses*
- *A review of approved service definitions in the waiver and determinations made about cost components that reflect costs necessary and related to the delivery of each service*
- *A review of the cost of implementing Federal, State and local statutes, regulations and ordinances.*

Providers are reimbursed on a statewide fee for service basis for Specialized Skill Development, Day Habilitation, Family Support, Career Planning, Nutritional Consultation, Residential Habilitation, Respite, Supported Employment, Supports Coordination, Temporary Supplemental Services, Therapies, Small Group Employment and Transportation-Trip.

Changes to the fee schedule are communicated through a public notice published in the Pennsylvania Bulletin prior to the effective date of any change or addition. Fee schedule rates are implemented prospectively.

ODP will complete studies of the costs associated with the provision of waiver services and the assumptions used to make the rate determinations in timeframes compliant with applicable state regulations and no later than the renewal of the waiver (7/1/21).

Vendor Goods and Services: For Assistive Technology, Community Transition Services, Transportation (Public), Home Modifications, and Vehicle Modifications, providers are reimbursed at the invoice cost for the service or equipment provided. DHS reimburses those services based on the cost charged to the general public for the service or equipment.

Total costs may not exceed the limits in Appendix C-3 for each service unless an exception to the limit is requested of and approved by ODP.

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:*

Agency providers submit claims to the OMAP through PROMISe.

Billing validation is done first through PROMISe. PROMISe verifies participant information in the Client Information System (CIS), such as the participant's Master Client Index (MCI) number, name, the participant's eligibility status, and effective eligibility dates. PROMISe also verifies that the provider(s) and service(s) on the claim are enrolled providers of the services and the services are in the Adult Autism Waiver.

After validation of the above listed items occurs, the claim information is sent to HCSIS to be verified against the participant's ISP. If any of the information on the PROMISe claim is in conflict with the ISP, HCSIS sends an error code to PROMISe. PROMISe then suspends or rejects the claim. This system edit provides an upfront monitoring of eligibility status and authorized services as per the approved ISP. PROMISe notifies providers of rejected claims. Each denied claim has one or more denial codes associated with it that show the reasons for rejections. Providers can work through the denied claims to correct the error or errors and resubmit them. ODP reviews a customized summary report from Promise showing rejected claims on a quarterly basis.

ODP monitors provider's claims rejection status and provides necessary training and direction to limit such errors/rejections. For a random sample of participants, as part of the annual monitoring of providers, ODP compares paid claims data to provider records such as time sheets and reports of services rendered. ODP also interviews participants to assess whether participants' reporting of service delivery is consistent with claims data. For the Supports Coordination service, all contacts by the Supports Coordinators must be recorded in HCSIS. ODP reviews a sample of Supports Coordinator records each year to assess whether billing reflects the amount of Supports Coordination activity recorded in the notes.

Vendors paid by an OHCDS provider do not bill directly through the PROMISe system. The OHCDS is responsible for billing through the PROMISe system for services rendered by these vendors.

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:*

Provider billings are verified through PROMISe. PROMISe includes edits to determine if the participant is eligible for Medicaid payment on the date of service and ensure that the service was part of the participant's service plan. The service is approved for payment by PROMISe only if the service is authorized and there are sufficient units available on the participant's service plan. Validation that the service has been provided occurs through the audit process at the end of the year.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Many County Mental Health and Individuals with an Intellectual Disability(MH/IID) Programs have experience working with people who have autism spectrum disorders as well as a mental illness or intellectual disability diagnosis.

A County MH/IID agency can enroll for any service for which the organization meets the qualifications in Appendix C-3. DHS thoroughly reviews BHMCO contracts to ensure they do not include services available to BHMCO enrollees on a FFS basis such as Adult Autism Waiver services. In the unlikely event a BHMCO pays for an AAW service as an "in lieu of" service, the BHMCO is responsible for payment of those services. No additional state or federal expenditure is incurred.

Services listed in the waiver are Assistive Technology, Specialized Skill Development, Community Transition Services, Day Habilitation, Home Modifications, Vehicle Modifications, Family Support, Career Planning, Nutritional Consultation, Residential Habilitation, Respite, Supported Employment, Supports Coordination, Temporary Supplemental Services, Therapies, and Small Group Employment.

The process for counties is the same as for all other providers. During the provider application process, the ODP staff determines whether the provider meets the provider qualification criteria outlined in this waiver. If the provider meets the criteria, the ODP notifies the Office of Medical Assistance Programs (OMAP), that the provider has been determined qualified by ODP. OMAP then authorizes that provider to be added to ISPs of AAW participants and to bill against the AAW.

The ODP reviews provider qualifications at least biennially. If findings from discovery activities indicate a provider does not meet provider standards, the ODP will contact the provider for more information to assess whether the provider meets standards. If a provider does not meet provider standards, the ODP will give the provider 30 days to remediate the reason for ineligibility. The ODP will provide technical assistance and training to the provider during this time to prevent disenrollment and will advise the supports coordinator that the provider may be dis-enrolled. If the provider does not meet provider standards after 30 days, the ODP will dis-enroll the provider and notify the supports coordinator that participants will need to identify a new provider. The supports coordinator will notify the participant that a new provider is necessary. The ODP will send a notice of action to the provider to let the provider know that it can appeal the disenrollment decision to the DHS Bureau of Hearings and Appeals.

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:

◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers***

of the same service.

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment *(6 of 7)*

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

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

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

Appendix I: Financial Accountability

I-3: Payment *(7 of 7)*

g. Additional Payment Arrangements

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

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

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

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

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

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

(a) Supports Coordination organizations can apply to become OHCDS entities for the Adult Autism Waiver services of Community Transition Services, Assistive Technology, Home Modifications, Transportation and/or Vehicle Modifications. Supports Coordination organizations qualify for OHCDS designation because they provide Supports Coordination as a direct service. Specialized Skill Development agencies can apply to become OHCDS entities for the Adult Autism Waiver service of Assistive Technology, Transportation and/or Vehicle Modifications. Specialized Skill Development agencies qualify for OHCDS designation because they provide Specialized Skill Development as a direct service. Supported Employment agencies can apply to become OHCDS entities for the Adult Autism Waiver service of Transportation. Supported Employment agencies qualify for OHCDS designation because they provide Supported Employment as a direct service.

To assure that OHCDS subcontractors possess the required qualifications, when monitoring OHCDS, ODP reviews documentation that subcontractors possess the required qualifications.

When monitoring OHCDS, ODP will review documentation of the contracting mechanism between the OHCDS and the provider. OHCDS is allowed in this waiver for services for which providers are paid based on invoice costs—Home Modifications, Assistive Technology, Community Transition Services, Transportation (Public), Transportation-Trip and Vehicle Modifications. The cost of the service will vary based on the specific support a person needs – different providers will have different rates because of the different supports provided. The invoices for Transportation-Trip will be based on the rate schedule as described in I-2-a and not individual provider rates.

(b) Home Modifications, Community Transition Services, Assistive Technology, Transportation and Vehicle Modifications providers have the option to directly enroll as an Adult Autism Waiver provider should they not desire to work through an OHCDS.

There is no limitation or restriction on vendors or providers who wish to both directly enroll as providers as well as provide that service through an OHCDS. Any willing and qualified provider may enroll directly. OHCDS are not limited when contracting with vendors as long as they are qualified.

(c) Participants in the AAW receive a complete list of providers of all waiver services at the time of enrollment, during the annual plan review, and at any other time by request. The list of providers of Community Transition Services, Assistive Technology, Home Modifications, Transportation and Vehicle Modification Services includes both OHCDS and providers directly enrolled to provide those services. Participants may exercise the right of choice from among all those providers enrolled for the service.

(d) Agencies or individuals who provide Community Transition Services, Assistive Technology, Home Modifications, Transportation and Vehicle Modifications must meet all Adult Autism Waiver requirements. The Supports Coordinator must document the successful delivery or completion of the Community Transition, Assistive Technology, Home Modifications, Transportation and Vehicle Modifications services once completed.

(e) & (f) ODP reviews all ISPs and scrutinizes Community Transition Services, Assistive Technology, Home Modifications, Transportation and Vehicle Modifications (and all services) to ensure they are necessary, appropriate, and that expenditures are within the monetary limits for the service. Community Transition Services, Assistive Technology, Home Modifications, Transportation and Vehicle Modifications are subject to the same financial accountability oversight as other Adult Autism Waiver services. For a sample of Adult Autism Waiver participants, ODP reviews the Supports Coordination organization records and interviews with participants, family members, and provider staff to verify that services were furnished as billed. The sample is sufficient to obtain a 90% confidence level with a 10% margin of error. ODP will also ensure the arrangements between the OHCDS entity and the agency or individual providing the service meet OHCDS requirements. For Community Transition, Assistive Technology, Home Modifications, and Vehicle Modifications services, these arrangements may not be formal contracts as these services generally represent short-term or single purchase transactions.

The OHCDS-designated provider is the "provider of record" of the service. ODP holds the OHCDS accountable for the goods or services just as if they were the vendor. However, unlike other waiver services, the OHCDS may contract with a vendor to provide the goods or services as described in the service

definitions in the AAW. The OHCDS is responsible for:
• Identifying the vendor;
• Specifying the terms of the service (what exactly the vendor will do or provide);
• Accepting or negotiating the terms including the cost of the goods or services;
• Ensuring that the vendor meets provider requirements specified in the AAW, such as licensing;
• Ensuring that necessary permits are secured, and that the work meets standards of manufacture, installation, etc.
• Determining that the contracted goods or services are satisfactorily completed and should be paid;
• Receiving the invoice (including any receipts) from the vendor and paying the vendor directly.
• Billing the AAW through PROMISe for the exact amount of the invoice from the vendor;
• Retaining the invoice in its records.
As part of its annual monitoring activities, ODP verifies that the OHCDS met the above criteria if a participant in the monitoring sample received services using an OHCDS.

If an OHCDS is used, once the service has been rendered, the vendor with whom the OHCDS has contracted submits a bill or invoice to the OHCDS. The OHCDS bills PROMISe for the exact amount of the bill or invoice using the procedure code for the service and using the appropriate provider type and specialty codes for the service. PROMISe verifies that the OHCDS agency is enrolled to provide that service in the AAW and that the participant has that service authorized on their ISP. The OHCDS must retain all invoices related to the cost on file and available for review by ODP.

Methods for Direct Provider Enrollment when a Provider does not Voluntarily Agree to Contract with a Designated OHCDS:

Agencies wishing to provide Assistive Technology, Vehicle Modification, Home Modification, Transportation or Community Transition Services directly may enroll as AAW providers by following the same process as providers of other services in the AAW. Interested providers must first enroll with Pennsylvania's Office of Medical Assistance Programs. The provider then submits an application to provide services for the Adult Autism Waiver that is reviewed to ensure the provider meets the qualifications for the service(s) specified by the provider. If the provider meets the qualifications, the ODP Waiver Provider Agreement is executed.

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.***
- ( ) ***not selected***

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 except for respite service rendered outside his/her private residence in a licensed or certified respite facility. The fee schedule developed for all waiver services, except respite in a licensed or certified respite facility, does not include consideration for room and board. Those payments are based solely on service costs. Since payments are processed through the Commonwealth's MMIS system, PROMISe, the cost for room and board is not included with the exception of respite rendered in a licensed or certified respite facility.

For respite services provided outside his/her private residence in a licensed or certified respite facility, the rate includes both service costs and an allowance for room and board.

The method to assure that the costs of rent and food are not reimbursed:

As stated in Appendix C(2)(e), family members are only allowed to provide Community Supports, and Respite. A person who lives with the participant may not provide respite. As a result, the only service that may be provided by live-in caregivers is Community Supports.
The rate for family members is the same as the rate for any other provider. The rate does not include the cost of rent and food.

Rates are not based on cost reports and the AAW does not use administrative entities to administer the waiver.

Residential habilitation providers bill separate procedure codes for room and board. Room and board is NOT eligible for federal financial participation. PROMISe uses a separate account for these procedure codes so only state funds are used to pay for 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

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	39483.03	8329.65	47812.68	187803.64	6382.65	194186.29	146373.61
2		8750.00	8750.00	208832.00	8952.00	217784.00	209034.00
3		8750.00	8750.00	208832.00	8952.00	217784.00	209034.00
4		8750.00	8750.00	208832.00	8952.00	217784.00	209034.00
5		8750.00	8750.00	208832.00	8952.00	217784.00	209034.00

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	702	702
Year 2	702	702
Year 3	754	754
Year 4	754	754
Year 5	754	754

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.*

Years 1-2:

To calculate total days of service, the 668 persons served at one time are separated into three groups: people who disenroll, people who are enrolled for the full year, and people who newly enrolled during years 1 and 2.

1. Days of service for people who disenroll:
Based on the experience in previous waiver years, it is assumed 5% (34 people) will disenroll each year and 120 days will be necessary to enroll new people into the waiver. Capacity for 34 people will be used for an average of 245 days (365 - 120). Total is 8,330 days (34 people times 245 days).

2. Days of service for people enrolled in the full year:
Of the 668 people enrolled during years 1 and 2, 513 people (number of people enrolled as of July 1, 2016) will be served for the entire year. Total is 187,245 days (513 people times 365 days).

3. Days of service for people newly enrolled during waiver years 1 and 2:
Of the 668 people enrolled in years 1 and 2, 121 people (668-34-513) will be served for an average of 150 days. Total is 18,150 days (121 people times 150 days).

Total days of service: 8,330 + 187,245 + 18,150 = 213,725

Average length of stay for waiver years 1 and 2 is calculated as total days of service divided by the unduplicated number of participants: 213,725/702 = 305.

Years 3-5:

To calculate total days of service, the 718 persons served at one time are separated into two groups: people who disenroll and the people who are enrolled for the full year.

1. Days of service for people who disenroll:
Based on the experience in previous waiver years, it is assumed 5% (36 people) will disenroll each year and 120 days will be necessary to enroll new people into the waiver. Capacity for 36 people will be used for an average of 245 days (365 - 120). Total is 8,820 days (36 people times 245 days).

2. Days of service for people enrolled in the full year:
Of the 718 people enrolled during years 3-5, 682 people will be served for the entire year. Total is 248,930 days (682 people times 365 days).

Total days of service: 8,820 + 248,930 = 257,750

Average length of stay for waiver years 3-5 is calculated as total days of service divided by the unduplicated number of participants: 257,750/754 = 342.

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:*

For Factor D the assumptions made for average length of stay apply per Appendix J-2-b. Participant capacity, length of stay and fee schedule rates are assumed to be held constant, using the same methodology over the five years of the waiver cycle as well as length of stay, intake and service utilization methodology over the five years.

Data for paid claims for SFY 2014/15 through SFY 2017/18 and the first 2 quarters of SFY 2018/19, extracted from the DHS data warehouse, were used as the basis for Factor D for most services.

Data for SFY 2014/15 through SFY 2017/18 and the first 2 quarters of SFY 2018/19 were analyzed to identify utilization trends for each service. Data from the first 2 quarters of SFY 2018/19 were analyzed to confirm consistency with the identified utilization trends. For most services, it is assumed the percentage of participants using each service for which data is available for the amendment will remain the same as in paid claims for SFY 2014/15 through SFY 2017/18 and the first 2 quarters of SFY 2018/19. Consistent with previous utilization patterns, it is assumed that service utilization will increase over time during the first two years participants receive waiver services. Exceptions to these assumptions include a new service, Transportation. Projections of utilization of the new Transportation service are based on utilization experience in the Consolidated and P/FDS waivers administered by ODP.

For services that had no paid claims in SFY 2016/17 and SFY 2017/18: Speech Therapy, Community Transition Services, one user is assumed per year. Average units per user are assumed to be the same as in Appendix J of the most recent renewal.

The average cost for all services are based on the rates set according to the methods described in Appendix I-2-a. For services without rates (Community Transition Services, Assistive Technology and Home and Vehicle Modifications) average costs in the most recent renewal is used for average cost.

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:*

For WY 1, Factor D' at J-1, column 3 is $8,329.65, the Factor D' value reported in the 372 Report for SFY 2014/15.

For WY 2-5, Factor D' at J-1, column 3 is $8,750, the Factor D' value reported in the most recent 372 Report for SFY 2016/17. That level is held constant for WY 2-5.

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:*

For WY 1, Factor G is derived from the 372 Report for SFY 2014/15.

For WY 2-5, Factor G is derived from the most recent 372 Report for SFY 2016/17 and held constant for WY 2-5.

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 WY 1, Factor G' is derived from the 372 Report for SFY 2014/15.

For WY 2-5, Factor G' is derived from the most recent 372 Report for SFY 2016/17 and held constant for WY 2-5.

Estimates of Factor G' ***do not include the costs of prescribed drugs that will be furnished to Medicare/Medicaid dual eligibles under the provisions of Part D.***

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	
Day Habilitation	
Residential Habilitation	
Respite	
Supported Employment	
Supports Coordination	
Therapies	
Assistive Technology	
Career Planning	
Community Transition Services	
Family Support	
Home Modifications	
Nutritional Consultation	
Small Group Employment	
Specialized Skill Development	
Temporary Supplemental Services	
Transportation	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						131448.46
Day Habilitation	15 min.	11	2242.00	5.33	131448.46	
Residential Habilitation Total:						4204546.80
Community Home	Day	42	310.00	296.44	3859648.80	
Family Living Home	Day	9	300.00	127.74	344898.00	
Respite Total:						210032.73
Out of Home- Daily					92739.24	
GRAND TOTAL:						27717089.33
Total Estimated Unduplicated Participants:						702
Factor D (Divide total by number of participants):						39483.03
Average Length of Stay on the Waiver:						305

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	22	22.00	191.61		
Out of Home-15 min	15 min.	9	59.00	4.79	2543.49	
In-home-15 min	15 min.	50	375.00	6.12	114750.00	
Respite		0	0.00	0.00	0.00	
Supported Employment Total:						1064011.50
Intensive Job Coaching	15 min.	114	830.00	10.95	1036089.00	
Extended Employment Supports	15 min.	34	75.00	10.95	27922.50	
Supports Coordination Total:						2024141.43
Supports Coordination	15 min	668	165.00	17.05	1879251.00	
Supports Coordination Initial Plan Development	Plan	177	1.00	818.59	144890.43	
Therapies Total:						103398.43
Therapies - Counseling	15 min.	49	99.00	21.29	103277.79	
Therapies - Speech	15 min.	1	8.00	15.08	120.64	
Assistive Technology Total:						1300.00
Assistive Technology	Item	2	1.00	650.00	1300.00	
Career Planning Total:						54875.25
Vocational Assessment	15 min.	22	40.00	13.05	11484.00	
Job Finding	15 min.	35	95.00	13.05	43391.25	
Community Transition Services Total:						4578.57
Community Transition Services	Item	1	1.00	4578.57	4578.57	
Family Support Total:						6930.56
Family Support	15 min.	14	26.00	19.04	6930.56	
Home Modifications Total:						3815.00
Home Modifications	Item				3815.00	

GRAND TOTAL:	27717089.33
Total Estimated Unduplicated Participants:	702
Factor D (Divide total by number of participants):	39483.03
Average Length of Stay on the Waiver:	305

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1	1.00	3815.00		
Nutritional Consultation Total:						29906.25
Nutritional Consultation	15 min.	25	75.00	15.95	29906.25	
Small Group Employment Total:						18886.86
Small Group Employment	15 min.	1	5958.00	3.17	18886.86	
Specialized Skill Development Total:						19856409.49
Behavior Specialist Services- Ongoing Consultative	15 min.	415	230.00	18.37	1753416.50	
Behavior Specialist Services- Ongoing Direct	15 min.	415	486.00	18.37	3705045.30	
FBA and BSP/CIP Development	Plan	73	1.00	1469.93	107304.89	
Systematic Skill Building - Ongoing Direct	15 min.	50	145.00	15.37	111432.50	
Systematic Skill Building - Ongoing Consultative	15 min.	50	35.00	15.37	26897.50	
Systematic Skill Building - Skill Building Plan Development	unit	50	1.00	491.76	24588.00	
Community Support 1:1	15 min.	600	2616.00	9.00	14126400.00	
Community Support 1:2	15 min.	5	45.00	5.00	1125.00	
Community Support 1:3	15 min.	3	20.00	3.33	199.80	
Temporary Supplemental Services Total:						900.00
Temporary Supplemental Services	15 min	2	50.00	9.00	900.00	
Transportation Total:						0.00
Transportation	0	0	0.00	0.01	0.00	
Vehicle Modifications Total:						1908.00
Vehicle Modifications	unit	1	1.00	1908.00	1908.00	

GRAND TOTAL:	27717089.33
Total Estimated Unduplicated Participants:	702
Factor D (Divide total by number of participants):	39483.03
Average Length of Stay on the Waiver:	305

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						214607.12
Day Habilitation	15 min.	14	2876.00	5.33	214607.12	
Residential Habilitation Total:						4613802.00
Community Home	Day	50	288.00	300.00	4320000.00	
Family Living Home	Day	10	230.00	127.74	293802.00	
Respite Total:						
Out of Home- Daily	Day	15	46.00	191.61	132210.90	
Out of Home-15 min	15 min.	4	248.00	4.79	4751.68	
In-home-15 min	15 min.	31	900.00	6.12	170748.00	
Respite						
Supported Employment Total:						941700.00
Intensive Job Coaching	15 min.	80	900.00	10.95	788400.00	
Extended Employment Supports	15 min.	80	175.00	10.95	153300.00	
Supports Coordination Total:						2127849.50
Supports Coordination	15 min	680	180.00	17.05	2086920.00	
Supports Coordination Initial Plan Development	Plan	50	1.00	818.59	40929.50	
Therapies Total:						101270.32
Therapies - Counseling	15 min.	41	116.00	21.29	101255.24	
Therapies - Speech	15 min.				15.08	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	702
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	305

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1	1.00	15.08		
Assistive Technology Total:						**1000.00**
Assistive Technology	Item	5	1.00	200.00	**1000.00**	
Career Planning Total:						**154642.50**
Vocational Assessment	15 min.	20	92.00	13.05	**24012.00**	
Job Finding	15 min.	55	182.00	13.05	**130630.50**	
Community Transition Services Total:						**4578.57**
Community Transition Services	Item	1	1.00	4578.57	**4578.57**	
Family Support Total:						**9139.20**
Family Support	15 min.	10	48.00	19.04	**9139.20**	
Home Modifications Total:						**3815.00**
Home Modifications	Item	1	1.00	3815.00	**3815.00**	
Nutritional Consultation Total:						**28231.50**
Nutritional Consultation	15 min.	30	59.00	15.95	**28231.50**	
Small Group Employment Total:						**6149.80**
Small Group Employment	15 min.	2	970.00	3.17	**6149.80**	
Specialized Skill Development Total:						**20830391.58**
Behavior Specialist Services- Ongoing Consultative	15 min.	420	247.00	18.37	**1905703.80**	
Behavior Specialist Services- Ongoing Direct	15 min.	420	567.00	18.37	**4374631.80**	
FBA and BSP/CIP Development	Plan	40	1.00	1469.93	**58797.20**	
Systematic Skill Building - Ongoing Direct	15 min.	125	452.00	15.37	**868405.00**	
Systematic Skill Building - Ongoing Consultative	15 min.	125	180.00	15.37	**345825.00**	
Systematic Skill Building - Skill Building Plan Development	unit	48	1.00	491.76	**23604.48**	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	**702**
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	305

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Support 1:1	15 min.	600	2450.00	9.00	13230000.00	
Community Support 1:2	15 min.	20	144.00	5.00	14400.00	
Community Support 1:3	15 min.	5	542.00	3.33	9024.30	
Temporary Supplemental Services Total:						9.00
Temporary Supplemental Services	15 min	1	1.00	9.00	9.00	
Transportation Total:						0.00
Transportation	0	0	0.00	0.01	0.00	
Vehicle Modifications Total:						1908.00
Vehicle Modifications	unit	1	1.00	1908.00	1908.00	
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			702
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:			305

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						249444.00
Day Habilitation	15 min.	15	3120.00	5.33	249444.00	
Residential Habilitation Total:						5704150.00
Community Home	Day	50	365.00	298.00	5438500.00	
Family Living Home	Day	7	330.00	115.00	265650.00	
Respite Total:						
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			754
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:			342

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Out of Home- Daily	Day	5	35.00	191.61	33531.75	
Out of Home-15 min	15 min.	5	120.00	4.79	2874.00	
In-home-15 min	15 min.	30	865.00	6.12	158814.00	
Respite						
Supported Employment Total:						781830.00
Intensive Job Coaching	15 min.	65	960.00	10.95	683280.00	
Extended Employment Supports	15 min.	50	180.00	10.95	98550.00	
Supports Coordination Total:						2454521.80
Supports Coordination	15 min	715	200.00	17.05	2438150.00	
Supports Coordination Initial Plan Development	Plan	20	1.00	818.59	16371.80	
Therapies Total:						76659.08
Therapies - Counseling	15 min.	40	90.00	21.29	76644.00	
Therapies - Speech	15 min.	1	1.00	15.08	15.08	
Assistive Technology Total:						2100.00
Assistive Technology	Item	6	1.00	350.00	2100.00	
Career Planning Total:						112230.00
Vocational Assessment	15 min.	10	85.00	13.05	11092.50	
Job Finding	15 min.	50	155.00	13.05	101137.50	
Community Transition Services Total:						4578.57
Community Transition Services	Item	1	1.00	4578.57	4578.57	
Family Support Total:						8568.00
Family Support	15 min.	10	45.00	19.04	8568.00	
Home Modifications Total:						3815.00
Home					3815.00	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	754
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	342

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modifications	Item	1	1.00	3815.00		
Nutritional Consultation Total:						11165.00
Nutritional Consultation	15 min.	20	35.00	15.95	11165.00	
Small Group Employment Total:						22824.00
Small Group Employment	15 min.	2	3600.00	3.17	22824.00	
Specialized Skill Development Total:						26472143.00
Behavior Specialist Services- Ongoing Consultative	15 min.	425	290.00	18.37	2264102.50	
Behavior Specialist Services- Ongoing Direct	15 min.	425	630.00	18.37	4918567.50	
FBA and BSP/CIP Development	Plan	20	1.00	1469.93	29398.60	
Systematic Skill Building - Ongoing Direct	15 min.	180	630.00	15.37	1742958.00	
Systematic Skill Building - Ongoing Consultative	15 min.	180	240.00	15.37	663984.00	
Systematic Skill Building - Skill Building Plan Development	unit	30	1.00	491.76	14752.80	
Community Support 1:1	15 min.	600	3110.00	9.00	16794000.00	
Community Support 1:2	15 min.	20	240.00	5.00	24000.00	
Community Support 1:3	15 min.	2	3060.00	3.33	20379.60	
Temporary Supplemental Services Total:						6480.00
Temporary Supplemental Services	15 min	3	240.00	9.00	6480.00	
Transportation Total:						0.00
Transportation	15 min.	0	0.00	0.01	0.00	
Vehicle Modifications Total:						1908.00
Vehicle Modifications	unit	1	1.00	1908.00	1908.00	
				GRAND TOTAL:		
				Total Estimated Unduplicated Participants:		754
				Factor D (Divide total by number of participants):		
				Average Length of Stay on the Waiver:		342

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						257039.25
Day Habilitation	15 min.	15	3215.00	5.33	257039.25	
Residential Habilitation Total:						6856950.00
Community Home	Day	67	325.00	298.00	6488950.00	
Family Living Home	Day	10	320.00	115.00	368000.00	
Respite Total:						
Out of Home- Daily	Day	20	30.00	191.61	114966.00	
Out of Home-15 min	15 min.	20	100.00	4.79	9580.00	
In-home-15 min	15 min.	45	730.00	6.12	201042.00	
Respite						
Supported Employment Total:						941700.00
Intensive Job Coaching	15 min.	80	900.00	10.95	788400.00	
Extended Employment Supports	15 min.	80	175.00	10.95	153300.00	
Supports Coordination Total:						2171801.74
Supports Coordination	15 min	718	175.00	17.05	2142332.50	
Supports Coordination Initial Plan Development	Plan	36	1.00	818.59	29469.24	
Therapies Total:						79852.58
Therapies - Counseling	15 min.	50	75.00	21.29	79837.50	
Therapies - Speech	15 min.				15.08	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	754
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	342

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1	1.00	15.08		
Assistive Technology Total:						**3500.00**
Assistive Technology	Item	7	1.00	500.00	**3500.00**	
Career Planning Total:						**294930.00**
Vocational Assessment	15 min.	60	110.00	13.05	**86130.00**	
Job Finding	15 min.	80	200.00	13.05	**208800.00**	
Community Transition Services Total:						**4578.57**
Community Transition Services	Item	1	1.00	4578.57	**4578.57**	
Family Support Total:						**19040.00**
Family Support	15 min.	20	50.00	19.04	**19040.00**	
Home Modifications Total:						**3815.00**
Home Modifications	Item	1	1.00	3815.00	**3815.00**	
Nutritional Consultation Total:						**23925.00**
Nutritional Consultation	15 min.	30	50.00	15.95	**23925.00**	
Small Group Employment Total:						**33285.00**
Small Group Employment	15 min.	3	3500.00	3.17	**33285.00**	
Specialized Skill Development Total:						**26937173.65**
Behavior Specialist Services- Ongoing Consultative	15 min.	450	300.00	18.37	**2479950.00**	
Behavior Specialist Services- Ongoing Direct	15 min.	450	600.00	18.37	**4959900.00**	
FBA and BSP/CIP Development	Plan	20	1.00	1469.93	**29398.60**	
Systematic Skill Building - Ongoing Direct	15 min.	227	575.00	15.37	**2006169.25**	
Systematic Skill Building - Ongoing Consultative	15 min.	227	220.00	15.37	**767577.80**	
Systematic Skill Building - Skill Building Plan Development	unit	50	1.00	491.76	**24588.00**	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	754
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	342

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Support 1:1	15 min.	630	2895.00	9.00	16414650.00	
Community Support 1:2	15 min.	39	1000.00	5.00	195000.00	
Community Support 1:3	15 min.	6	3000.00	3.33	59940.00	
Temporary Supplemental Services Total:						6615.00
Temporary Supplemental Services	15 min	3	245.00	9.00	6615.00	
Transportation Total:						182317.50
Transportation	unit	150	45.00	27.01	182317.50	
Vehicle Modifications Total:						1908.00
Vehicle Modifications	unit	1	1.00	1908.00	1908.00	
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			754
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:			342

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						257039.25
Day Habilitation	15 min.	15	3215.00	5.33	257039.25	
Residential Habilitation Total:						6856950.00
Community Home	Day	67	325.00	298.00	6488950.00	
Family Living Home	Day	10	320.00	115.00	368000.00	
Respite Total:						
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			754
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:			342

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Out of Home- Daily	Day	20	30.00	191.61	114966.00	
Out of Home-15 min	15 min.	20	100.00	4.79	9580.00	
In-home-15 min	15 min.	45	730.00	6.12	201042.00	
Respite						
Supported Employment Total:						941700.00
Intensive Job Coaching	15 min.	80	900.00	10.95	788400.00	
Extended Employment Supports	15 min.	80	175.00	10.95	153300.00	
Supports Coordination Total:						2171801.74
Supports Coordination	15 min	718	175.00	17.05	2142332.50	
Supports Coordination Initial Plan Development	Plan	36	1.00	818.59	29469.24	
Therapies Total:						79852.58
Therapies - Counseling	15 min.	50	75.00	21.29	79837.50	
Therapies - Speech	15 min.	1	1.00	15.08	15.08	
Assistive Technology Total:						2100.00
Assistive Technology	Item	6	1.00	350.00	2100.00	
Career Planning Total:						287752.50
Vocational Assessment	15 min.	55	110.00	13.05	78952.50	
Job Finding	15 min.	80	200.00	13.05	208800.00	
Community Transition Services Total:						4578.57
Community Transition Services	Item	1	1.00	4578.57	4578.57	
Family Support Total:						19040.00
Family Support	15 min.	20	50.00	19.04	19040.00	
Home Modifications Total:						3815.00
Home					3815.00	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	754
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	342

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modifications	Item	1	1.00	3815.00		
Nutritional Consultation Total:						26317.50
Nutritional Consultation	15 min.	33	50.00	15.95	26317.50	
Small Group Employment Total:						33285.00
Small Group Employment	15 min.	3	3500.00	3.17	33285.00	
Specialized Skill Development Total:						26882745.35
Behavior Specialist Services- Ongoing Consultative	15 min.	450	300.00	18.37	2479950.00	
Behavior Specialist Services- Ongoing Direct	15 min.	450	600.00	18.37	4959900.00	
FBA and BSP/CIP Development	Plan	20	1.00	1469.93	29398.60	
Systematic Skill Building - Ongoing Direct	15 min.	225	575.00	15.37	1988493.75	
Systematic Skill Building - Ongoing Consultative	15 min.	225	220.00	15.37	760815.00	
Systematic Skill Building - Skill Building Plan Development	unit	50	1.00	491.76	24588.00	
Community Support 1:1	15 min.	630	2895.00	9.00	16414650.00	
Community Support 1:2	15 min.	35	1000.00	5.00	175000.00	
Community Support 1:3	15 min.	5	3000.00	3.33	49950.00	
Temporary Supplemental Services Total:						6615.00
Temporary Supplemental Services	15 min	3	245.00	9.00	6615.00	
Transportation Total:						243090.00
Transportation	15 min.	150	60.00	27.01	243090.00	
Vehicle Modifications Total:						1908.00
Vehicle Modifications	unit	1	1.00	1908.00	1908.00	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	754
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	342