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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

This waiver renewal makes changes consistent with the Office of Developmental Programs'(ODP) Everyday Lives philosophy and recommendations. The goal of the proposed changes are to:

- Simplify the system by aligning across all ODP programs and streamlining enrollment processes for providers.
- Enhance quality of services by increasing the number of qualified providers to meet the needs of the participants and families, as well as add a new service and enhance current services to promote independence and support families.

The changes in this waiver renewal reflect consideration of input from an array of stakeholders.

Notable changes included in this renewal are:

- Adding reserved capacity for individuals that will be discharged from a state center and individuals that will be returning to services after a period of incarceration.
- Clarification on expectations related to service monitoring, back-up plans, and assessments.
- Refinement of critical incident definitions, protocols, oversight of medication administration, systems for detection of inappropriate use of restraints, and oversight of restrictive interventions. Changes have been made to align with 55 Pa. Code Chapter 6100 regulations and the other three 1915(c) waivers administered by ODP.
- Addition of the Independent Monitoring for Quality (IM4Q) process for monitoring satisfaction and outcomes of participants.
- Update to the continuous quality improvement strategies to include the Plan-Do-Check-Act Model used by ODP.

Existing Services:

Day Habilitation:

- Renaming the service to Community Participation Support (CPS).
- Aligning the service definition, limitations, provider qualifications, and rate structure as much as possible with the CPS service in the other three 1915(c) waivers administered by ODP. This will improve consistency with policy, procedure, and service delivery for providers that are enrolled to provide services across programs.

Residential Habilitation and Life Sharing:

- Removing Life Sharing as a component of Residential Habilitation and making it a discrete service.
- Aligning the service definitions, limitations, provider qualifications, and rate structures as much as possible with the Residential Habilitation and Life Sharing services in the 1915(c) Consolidated Waiver administered by ODP. This will improve consistency with policy, procedure, and service delivery for providers that are enrolled to provide services across programs.
  - o Behavioral Specialist will be a component of the Residential Habilitation and Life Sharing service and rates.
  - o Experience requirements for executive staff will be added.
  - o Qualifications for an Assistive Technology Professional are defined for providers that render remote supports in Residential Habilitation.
  - o Settings where Residential Habilitation can be delivered will be expanded.
- Removing limitations and allowing participants who receive Residential Habilitation in any setting to receive Community Support outside of the licensed setting.
- Adding that relatives who meet provider qualifications will be able to provide Life Sharing services.
- Adding Supplemental Habilitation to Residential Habilitation and Life Sharing to provide enhanced staffing in emergency situations or to meet a participant’s temporary medical or behavioral needs.

Respite

- Aligning the service definition, limitations, provider qualifications, and rate structures as much as possible with the Respite service in the other three 1915(c) waivers administered by ODP. This will improve consistency with policy, procedure, and service delivery for providers that are enrolled to provide services across programs.
  - o Expanding settings where Respite can be delivered.
  - o Broadening service limitations.
- Expanding Respite to include an exceptional rate for licensed settings and a 2:1 staff-to-participant ratio for unlicensed or in-home settings to meet enhanced staffing needs of participants.

Supports Coordination – Revising provider qualifications for Supports Coordination Organizations (SCO) as follows:

- To be less stringent to allow for greater flexibility with hiring.
- Adding educational and training qualifications for Supports Coordinator Supervisors. Providers will be given six months from the effective date of the waiver to comply with these new requirements.
- Enhancing agency level qualifications to include a requirement for conflict-free policies, a maximum number of Supports Coordinators that can be supervised by a Supports Coordinator Supervisor, and clarification on other expectations.

Assistive Technology

- Adding independent living technology (remote support services and equipment) to assist participants in obtaining or

maintaining independence and safety and decrease their need for assistance from others.
• Expanding service definition to include payment for generators.
• Revising limitations on Assistive Technology.

Home Modifications:
• Replacing the requirement for an independent evaluation with a requirement for at least three bids for Home Modifications that cost more than $1,000 to provide consistency with the other three 1915(c) waivers administered by ODP.

Specialized Skill Development:
• Adding annual limitations on Systematic Skill Building for participants who receive Residential Habilitation.
• Adding a 2:1 staff-to-participant ratio to the Community Support service for use when participants have a behavioral or medical support need(s) that warrant enhanced staffing.

New Service:
Homemaker/Chore - This service will:
• Be used to support participants in their own homes (living with or without a family member).
• Deliver services needed to maintain the home in a clean, sanitary, and safe condition when neither the participant nor anyone else in the household is capable of performing the function and when no one else is capable or responsible for the function.
• Use the service definition, limitations, and provider qualifications from the other three 1915(c) waivers administered by ODP.

Remove the following services:
• Therapies (Counseling and Speech/Language)
  o Counseling is covered in the State Plan.
  o Speech/Language Therapy has not been utilized through the waiver for more than five years.

• Temporary Supplemental Services - will be removed from the waiver and the additional staffing that Temporary Supplemental Services provided will be met in the following ways:
  o Residential settings will now utilize supplemental habilitation
  o Community Support and Respite will be expanded to include a 2:1 staff-to-participant ratio.

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: renewal

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

○ **3 years** ◉ **5 years**

Draft ID: **PA.006.03.00**

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

Regular Waiver

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

07/01/21

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the

Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided 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 (currently known as the Bureau of Supports for Autism and Special Populations) 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, procedures, and rules for waiver operations. ODP authorizes services funded under the waiver, grants exceptions to service limitations, and monitors service providers.

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 a service plan. Participants are given choice of service providers from a list of all agencies enrolled to provide services.

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:

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:

Kozak

First Name: Sally

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) 705-5007 **Ext:** ☐ **TTY**

Fax:

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Pennsylvania**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Therapies (Counseling and Speech/Language) is being removed from the waiver. No participants have utilized the Speech/Language therapy service in more than five years. As of 11/10/2020, twelve participants were authorized to use Counseling. These participants will work with their service plan team to meet, discuss and identify other services and/or supports that will meet their needs by June 30, 2021.

Temporary Supplemental Services is being removed from the waiver. This service provided additional staff for a short period of time when a participant's health and safety was at risk. In order to meet the health and safety needs of participants, Supplemental Habilitation is being added to Residential Habilitation and Life Sharing to provide additional staffing on a short-term basis. In addition, Community Support is being expanded to include a 2:1 staff-to-participant ratio. Out-of-Home Licensed Respite is being expanded to include a process for ODP to grant an exceptional rate when additional staffing is needed. Unlicensed Out-of-home and In-home Respite are being expanded to include a 2:1 staff-to-participant ratio. As of 10/31/2020, five participants were authorized for Temporary Supplemental Services. Participants that continue to need additional staffing after June 30, 2021, will be able to transition to one of the new service options.

Participants impacted by new annual limitations on Systematic Skill Building when receiving Residential Habilitation services will have from July 1, 2021 through September 30, 2021 to meet with their service plan team to discuss and identify other services and/or supports that will meet the needs of the participants.

Participants impacted by new weekly limitations on CPS will have from July 1, 2021 through September 30, 2021 to meet with their service plan team to discuss and identify other services and/or supports that will meet the needs of the participants.

Participants impacted by new daily limitations on CPS and/or Community Support will meet with their service plan team to discuss and identify other services and/or supports that will meet their needs by June 30, 2021.

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):

Community Participation Support Service Definition (continued)

CPS 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).

Residential Habilitation Service Definition (continued)

Program capacity in licensed Community Homes or CRRS is limited to four individuals or the approved program capacity if it is fewer than four individuals. Approved program capacity is established by ODP for each service location based on the maximum number of individuals who, on any given day, may be authorized to receive services at that service location. There may be situations in which a site's licensed capacity is greater than the approved program capacity. In these situations, the site may only provide services up to the approved program capacity of four or fewer.

Life Sharing Service Definition (continued)

The Life Sharing provider agency must ensure that each participant has the right to:

1. Receive scheduled and unscheduled visitors, and to communicate and meet privately with individuals of his or her choice at any time.
2. Send and receive mail and other forms of communication, unopened and unread by others.
3. Have unrestricted and private access to telecommunications.
4. Manage and access his or her own finances.
5. Choose any individual with whom they will be sharing a bedroom.
6. Furnish and decorate his or her bedroom and to participate in decisions relating to furnishing and decorating the common areas of the home.
7. Lock his or her bedroom door.
8. Have a key to an entrance door of the home.
9. Decide what to eat, decide when to eat and have access to food at any time.
10. 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 service plan team and justified in the service plan. When any of these rights are modified due to requirements in a court order, the modification must still be included in the service plan and the plan must be implemented. Because the origin of the rights modification is a court order, team agreement is not a requirement for implementation of the modification.
Any use of Independent Living Technology must comply with 42 C.F.R. § 442.301(c)(4)(vi)(A) through (D) related to privacy, control of schedule and activities and access to visitors.

Room and board is not included in the rate for the Residential Habilitation service. Residential Habilitation providers should

collect room and board payments in accordance with regulatory requirements.

Assistive Technology Service Definition (continued)

When Assistive Technology is utilized to meet a medical need, documentation must be obtained stating that the service is medically necessary and not covered through the MA State Plan, Medicare and/or private insurance. When Assistive Technology is covered by the MA State Plan, Medicare and/or private insurance, documentation must be obtained by the Supports Coordinator showing that limitations have been reached before the Assistive Technology can be covered through the Waiver. To the extent that any listed services are covered under the State Plan, the services under the waiver would be limited to additional services not otherwise covered under the State Plan but consistent with waiver objectives of avoiding institutionalization.

Specialized Skill Development Service Definition (continued)

Community Support may be provided at four staff-to-participant levels:
- 1:3
- 1:2
- 1:1
- 2:1

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. The use of the 2:1 staff-to-participant level is based on the participant's behavioral or medical support needs. 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.