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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

Request for 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.R02.03

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

07/01/18

Approved Effective Date: 07/01/18
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 I, I-1 and Financial Accountability Quality Improvement, change the claims review sampling methodology to meet 95% reliability with +/- 5% margin of error. Also, change the sampling methodology for Performance Measure FA-1 to meet 95% reliability with +/- 5% margin of error by randomly selecting claims from the previous fiscal year across all participants served, not only the participants included in the annual monitoring sample.

This amendment is proposed to be retroactive to July 1, 2018.

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**	
☐ **Appendix B – Participant Access and Eligibility**	
☐ **Appendix C – Participant Services**	

Component of the Approved Waiver	Subsection(s)
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☐ Appendix J – Cost-Neutrality Demonstration	

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

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

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.R02.03
Draft ID: PA.006.02.04

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/IID 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/IID).

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. BAS is responsible for developing policies and procedures for waiver operations. Individuals request services through a toll free number at BAS. BAS regional staff and BAS 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 Agency with assistance from BAS 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:
Before publishing the proposed amendment, BAS presented the drafted revisions to the waiver to the Information Sharing Advisory Committee (ISAC) subcommittee that is specific to BAS stakeholders. BAS incorporated feedback from the subcommittee into the proposed amendment.

Through a notice published in the Pennsylvania Bulletin on March 4, 2017, DHS informed interested persons of the availability of the proposed amendment for public comment. The Pennsylvania Bulletin is available online at http://www.pabulletin.com/index.asp and via subscription. The Pennsylvania Bulletin is published weekly under 4 Pa.C.S. Part II (relating to publication and effectiveness of Commonwealth documents).

The notice also stated that paper copies of the waiver amendment document and the notice could be obtained by calling or submitting a request in writing to any of ODP's four regional offices.

Notice of the availability of paper copies of the waiver amendment document was shared via BAS's ListServ, which includes providers, advocates, supports coordinators and other interested parties.

The information contained in this renewal was presented at the Medical Assistance Advisory Committee on December 8, 2016.

Notification of the proposed waiver amendment was also done through stakeholder outreach via support groups and the ASERT Resource Center.

Tribal consultation was not required as Pennsylvania does not have any recognized tribes.

A total of 62 comments from the public were received on the AAW amendment.

20 comments asked for clarification or suggested future amendments. The State responded with additional information and that it would take suggestions for future changes to the waiver under consideration.

17 comments recommended revisions that were adopted by the State. These included suggestions of language modifications for clarity and alignment with changes that had been made to similar service definitions in other ODP waivers after the AAW amendment had been released for public comment.

11 comments were supportive of changes made in the amendment.

5 comments objected to elements of the HCBS Final Rule or the proposed State regulations under development to provide State regulatory authority for compliance with the HCBS Final Rule. The State responded that clarification will be included in the regulations when promulgated.

6 comments proposed changes that were not adopted. These included proposed additional language which the State determined was duplicative of existing or proposed language and unnecessary to add.

3 comments related to service reimbursement rates including dissatisfaction with current rates and a recommendation for disclosure of all components of rate setting. The State responded that BAS is in compliance with Federal regulations and guidance on rate setting and that rate increase requests are subject to Departmental budget approval.

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: Sep 28, 2018

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 the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in Pennsylvania's approved Statewide Transition Plan. Pennsylvania's Department of Human Services will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to this waiver when it submits the next amendment or renewal. The Statewide Transition Plan received initial approval on August 30, 2016.

The Transition Plan:

Remediation Strategies - BAS's overall strategy will rely heavily on its existing HCBS quality assurance processes to ensure provider compliance with the HCBS rule. This will include provider identification of remediation strategies for each identified issue and ongoing review of remediation status and compliance. BAS may also prescribe certain requirements to become compliant. BAS will also provide guidance and technical assistance to providers to assist in the assessment and remediation process. Providers that fail to remediate noncompliant settings in a timely manner may be subject to sanctions.

Unallowable Settings, Settings Presumed Not Eligible and All Settings Must Meet the Following Qualifications

#
Action Item
Description
Start Date - Target End Date
Deliverable

1 Explore employment data collection system
Explore employment data collection systems that will capture information on individuals served in the waiver such as type of job, wages, benefits and length of employment as well as information on providers rendering employment services. Recommendations will then be made as to the feasibility of a system and finally a decision will be made regarding whether employment data collection system can be implemented. Action Completed – ODP/BAS has determined that employment questions and responses will be captured in the Individual Monitoring tool used by Supports Coordinators.
November 2014-July 2015
Decision to determine if a system can be implemented

2 Draft Regulations
Create a draft of the 55 Pa. Code Chapter 6100 regulations with stakeholder input. These regulations will replace 55 Pa. Code Chapter 51 and govern home and community based services provided through the Adult Autism Waiver as well as other ODP programs. Create draft changes to 55 Pa. Code Chapters 2380 (relating to Adult Training Facilities), 6400 (relating to Community Homes for Individuals with Mental Retardation) and 6500 (relating to Family Living Homes). These changes will align with the CMS HCBS Final Rule and 55 Pa. Code Chapter 6100. Action Completed – ODP/BAS anticipates these drafts being released for public comment in April 2016 (see number 6 below).
January 2015-September 2015
Draft regulations

3 Draft and Publish Executive Order on Employment
Collaborate with other state departments, including the Departments of Education and Labor and Industry, and the Governor's Offices of Administration and Policy to draft for Governor's consideration and publish the Executive Order on Increasing Competitive Integrated Employment for People with a Disability. This document will clearly articulate employment principles for people with all disabilities. Action Completed – March 10th 2016 Tom Wolf, Governor signed Executive Order 2016-03 establishing "Employment First" policy which can be found at: https://www.governor.pa.gov/executive_orders/executive-order-2016-03-establishing-employment-first-policy-and-increasing-competitive-integrated-employment-for-pennsylvanians-with-a-disability/

January 2015-March 2016
Executive Order on Employment

4 Draft Waiver Service Definitions and Provider Qualifications
Draft waiver service definitions and provider qualification criteria with stakeholder input. This will include a two tiered set of standards: One that must be met by current providers and a different set of standards for providers that are newly enrolling to provide services.
April 2015-June 2016
Draft service definitions and provider qualifications

5 Implement In-Person and On-Line Training
Engage the SELN to provide training, resources and technical assistance to Supports Coordinators to engage in employment conversations. Collaborate with OVR to develop local trainings for OVR counselors, ODP staff, Supports Coordinators, Employment Providers, and Transition Coordinators to increase competitive integrated employment outcomes for students and adults.
June 2015- December 2016
Training Tools

6 Revise SC Monitoring Tool
Revise the tool used by Supports Coordinators when monitoring individuals to capture employment data and begin implementation of the revised tool.
November 2015-July 2016
Individual Monitoring Tool used by SCs

7 Build Provider Capacity for Competitive Integrated Employment
Provide comprehensive strategic consulting and mentoring of provider organizations shifting from a focus on facility-based service provision to supports aligned with competitive integrated employment in collaboration with the Office of Disability Employment Policy's Employment First State Leadership Mentoring Program.
December 2015 -December 2017
Training Tools

8 Public Comment on Regulations
Draft regulations will be published through notice in the Pennsylvania Bulletin for public comment.
July 2016-August 2016
Pennsylvania Bulletin Notice

9 Public Comment on Waiver Amendment
Draft waiver amendment changes will be published through notice in the Pennsylvania Bulletin for public comment.
October 2016-December 2016
Pennsylvania Bulletin Notice

10 Submit Final Waiver Changes to CMS
Submit final waiver amendment to CMS for approval.
July 2017-July 2017
Waiver Amendment

11 Identify where new required information is included in the ISP
Identify where the following will be documented in the ISP: •Setting options provided to individuals will be documented in the ISP •Modifications to one of the requirements when needed
January 2017-July 2017
HCBS IT Changes List, Document setting options

12 Develop communication
Develop and publish communication regarding required ISP documentation. This communication will include the additional information that must be included in the ISP when a modification to a requirement is needed.
January 2017-July 2017
Policy Document

13 Issue Regulations
Issue final regulations.
October 2017-October 2017

Pennsylvania Bulletin Notice

14 Enrollment process for new providers and service location move
Develop and implement a process to ensure new providers enrolling to render waiver services, existing providers moving their service locations and provider requests for expansion are not unallowable.
March 2017-June 2017
Enrollment Process

15 Review/Revise Provider Agreement
Review provider agreement and revise if necessary.
March 2017-June 2017
Provider Agreement

16 Provider Service Alignment with Waiver
Time for providers to analyze services rendered and make changes to comply with waiver. This includes compliance with the Day Habilitation service requirement that beginning July 1, 2019, participants may not receive services in a licensed facility for more than 75% of his or her support time, on average, per month. This also includes compliance with the requirement in the Day Habilitation service that, starting January 1, 2022, services may not be provided in any facility required to hold a 2380 license that serves more than 150 individuals at any one time.
March 2017-March 2020
No Deliverable For This Item

17 Develop/Distribute Training Tools and Policy Updates
Identify, develop, and distribute training tools and policy updates that are needed for compliance.
July 2017-March 2019
Training tools and policy updates

18 Revise Provider Monitoring Tool
Revise provider monitoring tool to capture new requirements in waiver amendments and regulations. This includes compliance with the Day Habilitation requirement that beginning July 1, 2019, participants may not receive services in a licensed facility for more than 75% of his or her support time, on average, per month. This also includes compliance with the requirement in Day Habilitation that, starting January 1, 2022, services may not be provided in any facility required to hold a 2380 license that serves more than 150 individuals at any one time.
March 2017-July 2022
Provider Monitoring Tool

19 Provider Self-Assessment
All Adult Autism Waiver providers will complete a self-assessment of their compliance with current applicable waivers, regulations and policies. This includes compliance with the Day Habilitation requirement that beginning July 1, 2019, participants may not receive services in a licensed facility for more than 75% of his or her support time, on average, per month. This also includes compliance with the requirement in Day Habilitation that, starting January 1, 2022, services may not be provided in any facility required to hold a 2380 license that serves more than 150 individuals at any one time.
September 2017-November 2022
Provider Tracking Tool

20 On-site Reviews of Providers
An onsite monitoring of all residential and day habilitation providers that serve participants in the Adult Autism Waiver will be conducted. An onsite review will also be completed for all waiver providers who either did not complete a self-assessment or whose self-assessments indicate noncompliance. The onsite review results will identify each of the areas of noncompliance identified during the monitoring process. The monitoring results are issued electronically, via email, by BAS. The monitoring results will identify each of the areas of noncompliance identified during the monitoring process. Once the monitored provider receives the monitoring results and Plan of Correction form, the monitored provider is responsible to complete a Plan of Correction and return it to BAS within 15 calendar days. If the monitored provider does not return it in 15 calendar days, BAS will send a directed Plan of Correction within 10 calendar days. BAS will then review and return the Plan of Correction indicating that the plan has been approved or that further clarification and/or correction is required. If further clarification is required, the monitored provider will have 15 calendar days to revise it and return it to BAS. All monitored providers completing a POC are advised to maintain documentation of the corrective actions taken. This information will be used for future validation activities. The type of documentation required should be in accordance with the specific monitoring process. In some cases, these corrective actions will be validated during future monitoring activities, or the monitored entities may be asked to submit documentation to the appropriate reviewing entity.
September 2017-June 2022

Provider Tracking Tool

21 Notify Providers of Decision
After the completion of the onsite monitoring reviews, settings that are presumed to have institutional qualities per the Centers for Medicare and Medicaid Services (CMS) requirements will be identified. When such settings are determined to have the qualities of a home and community-based setting, information on these settings will be submitted to CMS for heightened scrutiny. Providers will be notified of BAS' initial decision regarding the setting's eligibility. Providers determined to be ineligible will be provided appeal rights. Providers will be expected to comply with applicable 55 Pa. Code Chapter 6100 requirements.
August 2018-September 2022
Notification to providers

22 Notify Participant of Decision
Individuals served by providers determined to be ineligible will be notified of the provider's ineligibility and what actions participants may expect. Supports Coordination agencies will also be notified. This initial monitoring process will be complete in the summer of 2018. The ISP team must discuss the option of other willing and qualified providers or other services that will meet the individual's needs and ensure their health and safety. The Supports Coordinator will be responsible for documenting this discussion.
August 2018-September 2022
Notification to participants

23 Public Notice
A public notice will be published which will list the provider name, the county in which the setting is located, the waiver service (s) provided at the setting, and the number of individuals authorized to receive services in the setting along with the determination that the setting falls into one of the following categories: •Ineligible for waiver reimbursement as of March 2019, •Eligible for waiver reimbursement, or •Eligible for waiver reimbursement and meets criteria for CMS heightened scrutiny process.
November 2018-December 2022
Public Notice

24 Access Issues
Determine whether access issues may be created by providers who are no longer eligible/willing to provide waiver services. Access issues are defined as the inability of an individual/family to locate a willing and qualified service provider and/or the inability of a Supports Coordination Agency to secure a willing and qualified provider for individuals requesting services.
November 2018-December 2022
Provider Tracking Tool

25 Transition Participants
Ensure that individuals who receive services in ineligible settings transition to willing and qualified providers, if necessary. (This timeframe does not include individuals impacted by an access issue.)
December 2018 -March 2022
Provider Tracking Tool

26 CMS Heightened Scrutiny
Send list of settings/providers determined eligible in accordance with the waiver to CMS for Heightened Scrutiny process.
March 2019-March 2022
List of Eligible Providers

27 Ongoing Monitoring
All waiver providers are continuously monitored for compliance per waiver requirements. Providers will be monitored for compliance with applicable waivers, regulations and policies which will include compliance with the CMS HCBS Final Rule.
March 2019-Ongoing
Provider Tracking Tool

28 Public Notice of CMS Heightened Scrutiny Determination
Notice will be published in the Pennsylvania Bulletin regarding the settings/provider CMS accepted as being home and community based and those that CMS denied as being home and community based.
As determined by CMS-Ongoing
Public Notice

Requirements for Provider-owned or Controlled Home and Community Based Residential Settings

1 Analyze PA's Landlord Tenant Law
Analyze PA's landlord tenant law and determine what constitutes comparability for residential settings.
December 2015 -March 2016
Revised Room and Board Contract

2 Draft Regulations
Create a draft of the 55 Pa. Code Chapter 6100 regulations with stakeholder input. These regulations will replace 55 Pa. Code Chapter 51 and govern home and community based services provided through the Adult Autism Waiver as well as other ODP programs. Create draft changes to 55 Pa. Code Chapters 6400 (relating to Community Homes for Individuals with Mental Retardation) and 6500 (relating to Family Living Homes). These changes will align with the CMS HCBS Final Rule and 55 Pa. Code Chapter 6100. Action Completed – ODP anticipates these drafts being released for public comment in April 2016 (see number 5 below).
January 2015-September 2015
Draft regulations

3 Draft Waiver Service Definitions and Provider Qualifications Draft waiver service definitions and provider qualification criteria with stakeholder input. This will include a two tiered set of standards: One that must be met by current providers and a different set of standards for providers that are newly enrolling to provide services.
Action Complete - Waiver Service Definitions and Provider Qualifications were released for a 45-day public comment period during the 2016 waiver renewal and again for a 30-day public comment period on an amendment, beginning March 4, 2017.

April 2015-June 2016
Draft service definitions and provider qualifications

4 Determine which providers allow for a shared bedroom
Determine providers who allow for a shared bedroom. Initial action complete through provider survey released in April 2015. The report can be accessed at http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_209647.pdf
April 2015-June 2015 and ongoing
Provider Survey Results and Provider Tracking Tool

5 Public Comment on Regulations
Draft regulations will be published through notice in the Pennsylvania Bulletin for public comment.
Action Complete - Draft Chapter 6100 regulations were available for public comment from November 5, 2016 through December 20, 2016. The notice announcing the availability of the regulations for public comment can be accessed at http://www.pabulletin.com/secure/data/vol46/46-45/46_45_p2.pdf.

September 2016
November 2016
Pennsylvania Bulletin Notice

6 Revise Room and Board Contract
Revise and distribute updated Room And Board Contract.

March 2016-January 2017
Room and Board contract

7 Public Comment on Waiver Amendment
Draft waiver amendment changes will be published through notice in the Pennsylvania Bulletin for public comment.

Action Complete - Waiver amendment changes were released for a 30-day public comment period from March 4, 2017. The notice of public comment is available as PA Bulletin, Doc_ No_ 17-390.html.

October 2016-December 2016
Pennsylvania Bulletin Notice

8 Submit Final Waiver Changes to CMS
Submit final waiver amendment to CMS for approval.
Action Complete - The waiver amendment was submitted on July 31, 2017
July 2017-July 2017

Waiver Amendment

9 Identify where new required information is included in the ISP
Identify where the following will be documented in the ISP: •Setting options provided to individuals will be documented in the ISP •Modifications to one of the requirements when needed
January 2017-July 2017
HCBS IT Changes List, Document setting options

10 Develop communication
Develop and publish communication regarding required ISP documentation. This communication will include the additional information that must be included in the ISP when a modification to a requirement is needed.
January 2017-July 2017
Policy Document

11 Issue Regulations
Issue final regulations.
October 2017-October 2017
Pennsylvania Bulletin Notice

12 Enrollment process for new providers and service location move
Develop and implement a process to ensure new providers enrolling to render waiver services, existing providers moving their service locations and provider requests for expansion are not unallowable.
March 2017-June 2017
Enrollment Process

13 Review/Revise Provider Agreement
Review provider agreement and revise if necessary.
March 2017-June 2017
Provider Agreement

14 Provider Service Alignment with Waiver
Time for providers to analyze services rendered and make changes to comply with waiver. This includes compliance with the Day Habilitation service requirement that, beginning July 1, 2019, participants may not receive services in a licensed facility for more than 75% of his or her support time, on average, per month. This also includes compliance with the requirement that, starting January 1, 2022, services may not be provided in any facility required to hold a 2380 license that serves more than 150 individuals at any one time.
March 2017-March 2020
No Deliverable For This Item

15 Develop/Distribute Training Tools and Policy Updates
Identify, develop, and distribute training tools and policy updates that are needed for compliance.
July 2017-March 2019
Training tools and policy updates

16 Revise Provider Monitoring Tool
Revise provider monitoring tool to capture new requirements in waiver renewals and regulations.
March 2017-July 2022
Provider Monitoring Tool

17 Provider Self-Assessment
All Adult Autism Waiver providers will complete a self-assessment of their compliance with current applicable waivers, regulations and policies.
September 2017-November 2022
Provider Tracking Tool

18 On-Site Reviews of Providers
An onsite monitoring of all residential and day habilitation providers that serve participants in the Adult Autism Waiver will be conducted. An onsite review will also be completed for all waiver providers who either did not complete a self-assessment or whose self-assessments indicate noncompliance. The onsite review results will identify each of the areas of noncompliance identified during the monitoring process. The monitoring results are issued electronically, via email, by BAS. The monitoring results will identify each of the areas of noncompliance identified during the monitoring process. Once the monitored provider

receives the monitoring results and Plan of Correction form, the monitored provider is responsible to complete a Plan of Correction and return it to BAS within 15 calendar days. If the monitored provider does not return it in 15 calendar days, BAS will send a directed Plan of Correction within 10 calendar days. BAS will then review and return the Plan of Correction indicating that the plan has been approved or that further clarification and/or correction is required. If further clarification is required, the monitored provider will have 15 calendar days to revise it and return it to BAS. All monitored providers completing a POC are advised to maintain documentation of the corrective actions taken. This information will be used for future validation activities. The type of documentation required should be in accordance with the specific monitoring process. In some cases, these corrective actions will be validated during future monitoring activities, or the monitored entities may be asked to submit documentation to the appropriate reviewing entity.
September 2017-June 2022
Provider Tracking Tool

19 Notify Providers of Decision
After the completion of the onsite monitoring reviews, settings that are presumed to have institutional qualities per the Centers for Medicare and Medicaid Services (CMS) requirements will be identified. When such settings are determined to have the qualities of a home and community-based setting, information on these settings will be submitted to CMS for heightened scrutiny. Providers will be notified of BAS' initial decision regarding the setting's eligibility. Providers determined to be ineligible will be provided appeal rights. Providers will be expected to comply with applicable 55 Pa. Code Chapter 6100 requirements.
August 2018-September 2022
Notification to providers

20 Notify Participant of Decision
Individuals served by providers determined to be ineligible will be notified of the provider's ineligibility and what actions participants may expect. Supports Coordination agencies will also be notified. This initial monitoring process will be complete in the summer of 2018. The ISP team must discuss the option of other willing and qualified providers or other services that will meet the individual's needs and ensure their health and safety. The Supports Coordinator will be responsible for documenting this discussion.
August 2018-September 2022
Notification to participants

21 Public Notice
A public notice will be published which will list the provider name, the county in which the setting is located, the waiver service (s) provided at the setting, and the number of individuals authorized to receive services in the setting along with the determination that the setting falls into one of the following categories: •Ineligible for waiver reimbursement as of March 2019, •Eligible for waiver reimbursement, or •Eligible for waiver reimbursement and meets criteria for CMS heightened scrutiny process.
November 2018-December 2022
Public Notice

22 Access Issues
Determine whether access issues may be created by providers who are no longer eligible/willing to provider waiver services. Access issues are defined as the inability of an individual/family to locate a willing and qualified service provider and/or the inability of a Supports Coordination Agency to secure a willing and qualified provider for individuals requesting services.
November 2018-December 2022
Provider Tracking Tool

23 Transition Participants
Ensure that individuals who receive services in ineligible settings transition to willing and qualified providers, if necessary.
December 2018 -March 2022
Provider Tracking Tool

24 CMS Heightened Scrutiny
Send list of settings/providers determined eligible in accordance with the waiver to CMS for Heightened Scrutiny process.
March 2019-March 2022
List of Eligible Providers

25 Ongoing Monitoring
All waiver providers are continuously monitored for compliance per waiver requirements. Providers will be monitored for compliance with applicable waivers, regulations and policies which will include compliance with the CMS HCBS Final Rule.
March 2019-Ongoing

Provider Tracking Tool

26 Public Notice of CMS Heightened Scrutiny Determination
Notice will be published in the Pennsylvania Bulletin regarding the settings/provider CMS accepted as being home and community based and those that CMS denied as being home and community based.
As determined by CMS-Ongoing
Public Notice

Home and Community-Based Settings

The Supports Coordination service definition states that Supports Coordinators are responsible to use 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. This includes ensuring that services provided in the participant's private home and community as well as all residential and non-residential settings are integrated in and support full access to the community.

Waiver funding cannot be used to provide services in a private home purchased for, developed for or promoted as serving people with disabilities or in a manner that isolates or segregates the participant from the community of individuals not receiving waiver services.

Further, waiver funding cannot be used to provide any service in a private home that is:
• A farmstead where participants who live at the farm typically interact primarily with people with disabilities and staff who work with those individuals. Participants typically live in homes only with other people with disabilities and/or staff. Daily activities are typically designed to take place on-site so that a participant generally does not leave the farm to access services or participate in community activities. While sometimes people from the broader community may come on-site, participants from the farm do not go out into the broader community as part of their daily life.
• A gated/secured community for people with disabilities - Gated communities consist primarily of people with disabilities and the staff that work with them. Participants receiving services in this type of setting often do not leave the grounds of the gated community in order to access activities or services in the broader community.

The Day Habilitation and Residential Habilitation service definitions have been revised to comply with the HCB Settings requirements. The service definition for Day Habilitation contains standards for setting size and location.

The HCB Settings requirements have been incorporated into the Residential Habilitation service definition.

HCBS providers will complete a self-assessment in the fall of 2017. An onsite review will be completed for all the waiver providers who either did not complete a self-assessment or whose self-assessments indicate noncompliance with 42 C.F.R. § 441.301. An onsite monitoring of all residential and day habilitation providers that serve participants will also be conducted. The initial onsite monitoring reviews will be completed by June 2018. On an ongoing basis, each provider will be assessed to ensure that services are being delivered in a manner that comports with federal and state regulations as well as waiver requirements.

BAS shall also require prior to enrolling new providers, that the provider be assessed to confirm that its setting will fully comport with all federal and state regulations as well as waiver requirements.

Outreach & Engagement - ODP proposes to involve various stakeholders in the development and implementation of this transition plan.

1 Develop Communication Materials
Create Transition Plan Website links, link to register for webinars, public comment mailbox, information handouts, public communication brief. Action Complete – ODP specific documents can be accessed at http://dhs.pa.gov/learnaboutdhs/dhsorganization/officeofdevelopmentalprograms/ODPHCBS/index.htm Statewide documents can be accessed at http://www.dhs.pa.gov/citizens/hcbswaiver/
December 2014-December 2014
Communication Materials

2 Public Notice & Comment
Official notification through PA Bulletin to begin the public comment period on waiver amendments/revisions and published draft transition plan including: submission, consolidation, documentation, and review of public comments
December 2014-February 2015

Public notice

3 Stakeholder Webinars
Two webinars held to obtain public comment on proposed Adult Autism Waiver transition plan.Action Complete - The notice above shows that webinars were held on January 14, 2015 from 1pm to 4pm and January 15, 2015 from 9am to 12pm.
January 2015-January 2015
Public Notice, Notes from Webinar

4 Transition Plan Revision
Incorporation of stakeholder comment and feedback on the Adult Autism Waiver transition plan, submission of final waiver amendment and transition plan to CMS, and publication of submitted plan and comments received and BAS responses. Action Complete – The ODP public comment and response document as well as the summary of changes made to the ODP transition plans can be accessed
at http://dhs.pa.gov/learnaboutdhs/dhsorganization/officeofdevelopmentalprograms/ODPHCBS/index.htm
February 2015-March 2015
Waiver Amendment, Transition Plan, Comment and Response Document

5 ODP Stakeholder Meetings
Provide stakeholders with an overview of the CMS HCBS Final Rule and obtain feedback from stakeholders to help in the development of recommendations to help Pennsylvania come into compliance with the CMS final rule. Action Complete – Meetings were held April 6 – 8, 2015.
April 2015-April 2015
Summary of Stakeholder Input

6 ODP Stakeholder Workgroup
ODP stakeholder workgroup will be developed to assist ODP in drafting waiver service definitions and provider qualification criteria.
October 2015-March 2016
Draft service definitions and provider qualifications

7 Provider & Stakeholder Training
On-going engagement highlighting updates and revisions to Pennsylvania's regulations, policies, and procedures; training on compliance to the HCBS Final Rule and transitioning activities for individuals with an intellectual disability, families, supports coordinators, providers, and staff. A webcast providing an overview of the CMS HCBS Final Rule was released in September 2015 and can be accessed at http://www.odpconsulting.net/resources/webcasts-videos/cms-final-rule/
April 2015-March 2019
Training, Stakeholder Involvement Plan

8 Ongoing Stakeholder Engagement
Continued engagement with stakeholder community on regulations and department updates, sustaining an inclusive, person-centric focus that is transparent to individuals and the community while providing accountability to all parties involved.
December 2014-March 2019
Stakeholder Involvement Plan

9 Develop Provider Base
Provide ongoing engagement with service providers to help build capacity for provision of services in more integrated settings.
January 2016-March 2019 and ongoing
Strategy document for developing an enhanced provider base

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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 Autism Services (BAS)
(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 Autism Services 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 Autism Services to discuss autism services including the waiver. In addition, the State Medicaid Director meets monthly with BAS 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.:*
   BAS contracts with individuals across the Commonwealth to conduct functional eligibility assessments for people who have applied for the waiver. Individuals may be employed by a contracted agency or may be independent contractors. The individuals meet the applicant and his/her representative in-person and conduct the functional eligibility assessment using criteria in Appendix B-1-b. BAS conducts functional eligibility assessments when contractors are not available or do not have the capacity to conduct the assessment within 30 days of receipt of an application. Individuals who conduct functional eligibility assessments must a) have completed required training developed by the BAS; and b) have a Bachelor's degree in Social Work, Psychology, Education, or a human services field related to Social Work, Psychology or Education; or a High School diploma or its equivalent and two years of experience working with individuals with disabilities in a Home and Community Based setting.

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

Appendix A: Waiver Administration and Operation

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

   (●) **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
   Bureau of Autism Services

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:
BAS staff review documentation of all denials of functional eligibility before the applicant is notified of a denial. BAS staff also review all approvals of functional eligibility where the applicant has substantial functional limitations in only three of the six major life activities specified in Appendix B-1-b before the applicant is notified of approval or denial. In addition, BAS staff review 20% of other functional eligibility determinations that results in an approval (every fifth assessment by each contracted assessor) on an ongoing basis. BAS staff can either require new information or override the determination by the functional eligibility assessment contractor.

   Within 2 business days of receiving the assessment, the BAS staff determines if it requires clinical review. Clinical review is required if the applicant's functional limitations are at or below 3 out of 6 areas of major life activity. Clinical then has a total of 5 days to determine if the applicant meets the AAW functional eligibility requirement or not, which includes obtaining new information to determine eligibility if necessary.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Performance Measure AA1: Number and percent of functional eligibility (FE) determinations conducted by contracted entities consistent with waiver requirements. Numerator = Number of FE determinations conducted by contracted entities consistent with waiver requirements. Denominator = Number of FE determinations conducted by contracted entities.

Data Source (Select one):
Other
If 'Other' is selected, specify:
BAS'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: 100% of denials, 100% of approvals of those with substantial functional limitations in only 3 of the 6 major life activities listed in Apdx B-1-b. 20% of all remaining approvals.

	☐ **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 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 AA3: Number and percent of providers with signed Medical Assistance Provider Agreements and AAW Supplemental Agreements. Numerator = Number of providers with signed Medical Assistance Provider Agreements and AAW Supplemental Agreements. Denominator = Number of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
BAS'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 AA4: Number and percent of participants distributed by region utilizing the geographic distribution criteria identified in Appendix B-3 of the waiver. Numerator = Number of participants distributed by region utilizing the geographic distribution criteria identified in Appendix B-3 of the waiver. Denominator = Number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
BAS'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**
☐ **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. To verify the accuracy of functional eligibility dates used for the performance measure in a.i.a., BAS reviews paper records for a sample of functional eligibility determinations. Since BAS staff conduct some determinations as identified in Appendix B-6-a, a BAS staff person may not review his or her own determination. The sample is sufficient to obtain a 90% confidence level with a 10% margin of error. For each assessment reviewed, BAS compares the date of assessment in the Participant Tracking Database to the date listed on the paper record. BAS also checks the individual's application to ensure the Participant Tracking Database is accurate regarding the date the application was received. Finally, BAS staff review data regarding functional eligibility assessments to identify if any assessors are outliers in approval or denial of functional eligibility, and observe interviews for any assessors that are outliers to review their application of functional eligibility criteria.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Each quarter, BAS reviews information collected from the discovery activities during that quarter. BAS staff meet quarterly to discuss findings and identify remediation strategies if necessary. If there are multiple issues of performance, the BAS Director or designee will set priorities regarding which issue to address first.

If the information indicates that there are issues of non-compliance with the waiver requirements for functional eligibility determinations, BAS will first assess whether the problems are system-wide or isolated to a particular contractor or region.

If problems are system-wide, the BAS Director or a designee will meet with individuals involved in the administrative function. For example, if functional eligibility determinations are not timely completed on a systemic basis, BAS staff who make functional eligibility determinations would meet with contracted individuals who perform functional eligibility determinations. During the meeting systemic issues that lead to untimely performance or instances where BAS overrides the assessor's decision would be identified and possible solutions such as training, technical assistance, more intensive monitoring, or process changes would be discussed. The BAS Director or designee will then develop a performance improvement project to address the issue.

If performance issues are isolated to only one region, contractor, or provider, the BAS Director or designee will communicate with the responsible DHS staff, contractor, or provider to identify the reason for the issues with performance. In addition, BAS may interview participants, family members, and providers, and/or review additional records, as necessary. The BAS Director or designee will determine corrective action based on the data collected and the previous performance of the staff person or provider. Examples of corrective action include additional training, more intensive monitoring by BAS, follow-up and resolution through a corrective action plan. For performance issues with contractors, BAS will follow DHS departmental policy regarding sanctions and, if warranted, termination of the contract.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ 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/IID) services,and

• Have a diagnosis of Autism Spectrum Disorder (ASD) before the age of 22 as determined by a licensed psychologist, 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

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

Waiver Year	Unduplicated Number of Participants
Year 1	702
Year 2	702
Year 3	702
Year 4	702
Year 5	702

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	668
Year 4	668
Year 5	668

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	

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

Waiver Year	Capacity Reserved
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 (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:

Prioritization Criteria

BAS prioritizes entry into the waiver based on four criteria: use of long-term support services; geographic distribution of capacity; a lottery that was held to help determine the order of application for requests for service during the first six weeks of the waiver; and the date and time of requests for service received after the first six weeks of the waiver.

- Use of Long-Term Support Services

Since the intent of the Adult Autism Waiver is to serve new individuals, BAS prioritizes entry as follows:

Priority 1. People 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).

-Priority 2. If waiver capacity remains, the waiver will serve people who do not meet Priority 1 criteria. Priority 2 individuals will only receive applications if waiver capacity remains available after all Priority 1 individuals across the Commonwealth have had their applications processed.

- Geographic Distribution

Within each priority group, BAS 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 BAS 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.

-Lottery for Requests for Service during the First Six Weeks

When the waiver began on July 1, 2008, the Commonwealth collected requests for services for a six-week period using the Intake Process described below. Then BAS randomly assigned a number to each Priority 1 individual for whom services were requested during the six-week period. Applications have been sent to all Priority 1 individuals who received a randomly assigned number. There are no Priority 1 individuals on the interest list for the Adult Autism

Waiver from the initial six-week period.

BAS also randomly assigned a number to each Priority 2 individual for whom services were requested during the six-week period. Priority 2 individuals who received a randomly assigned number remain on the interest list for the Adult Autism Waiver.

-Date and Time of Requests for Service Received After the Initial Six-Week Period

The Intake Process described below continues to be used. Within each priority group and region, BAS sends applications in chronological order based on the date and time BAS received a request for services.

Intake Process

Individuals can request services by calling the BAS publicized, toll-free telephone number and leaving a message; by completing the Information and Referral Tool (IRT) that is available on-line; or by requesting to be contacted through an on-line site called COMPASS. The IRT website and COMPASS will also include the toll-free telephone number. The IRT and COMPASS will allow the person to enter their name and contact information into a form. When a person completes the form, the person's name and contact information will be emailed to BAS staff with a date and time stamp. If the person chooses to leave a message on the toll-free telephone number, the voice message system will also record the date and time stamp of the call. This date and time stamp will be used to determine the order in which the person is listed on the interest list.

Using the information obtained through the telephone contact, the IRT, or COMPASS, BAS checks the Department's management information systems to identify whether the person is currently receiving on-going long-term support services in order to establish whether the person is a Priority 1 or Priority 2 individual. BAS also contacts the person's County Mental Health Agency to identify whether the person is currently receiving services in a Community Residential Rehabilitation Services; services in a Long-Term Structured Residence; Residential Treatment Facility; or extended acute care for people with serious mental illness

BAS returns each contact request to verify the person's (and, if applicable, representative's) contact information. BAS prioritizes requests for services based on the criteria described in the Prioritization Criteria section above.

When waiver capacity is available to a person and the person is over the age of 21, BAS will send the person and representative (if applicable) an application. If waiver capacity is available and the person's age is between 18 and 21 years of age, BAS will wait until the person turns 21 years of age and waiver capacity is again available to send the person and representative (if applicable) an application.
BAS assists the person or representative if necessary to complete the application and the person or representative may call BAS for assistance. When the person and/or representative returns the application, BAS staff, with assistance as necessary from the functional eligibility contractors described in Appendix A, determine whether the person meets the eligibility requirements specified in Appendix B-1. If BAS determines the person is not eligible for the waiver, BAS 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 a BAS staff person. The APS liaison is responsible for coordinating the waiver enrollment process within BAS.

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

Interest List Procedure

If the waiver capacity in a region is filled, individuals requesting services will be placed on an interest list until capacity is available. If waiver capacity becomes available in a region, Priority 1 individuals on the interest list in that region will receive applications in chronological order based on the date and time BAS received a request for waiver services.

If waiver capacity remains available in a region after all Priority 1 requests from that region have been processed, BAS will apply the Unused Capacity Procedure.

Unused Capacity Procedure

If a region does not have enough Priority 1 applicants to use available waiver capacity, BAS will monitor the number of Priority 1 requests for services received in the next 90 calendar days. BAS will send applications to Priority 1 individuals who request services during this time in chronological order until the region's waiver capacity is used. If the region still has waiver capacity after 90 calendar days, BAS will reallocate unused capacity to regions where Priority 1 individuals are on an interest list. BAS will reallocate capacity to these regions in proportion to each region's population age 21 or older based on the most recently available version of the U.S. Census Bureau's Current Population Estimates.

If waiver capacity remains available after all Priority 1 individuals have had their applications processed, BAS will return the remaining waiver capacity to the original region (i.e., the region that did not have enough Priority 1 individuals to use its capacity). BAS will first send applications to Priority 2 individuals in this region who requested services during the initial six-week period, in order of their randomly assigned number. If capacity remains available, BAS will send applications to Priority 2 individuals in this region who requested services after the six-week period, in chronological order. If the region still has waiver capacity after processing all requests from Priority 2 individuals in that region, BAS will reallocate unused capacity to regions where Priority 2 individuals are on an interest list. BAS first will send applications to Priority 2 individuals who requested services during the initial six-week period, in order of their randomly assigned number. BAS will then send applications to Priority 2 individuals who requested services after the six-week period, in chronological order.

CHANGE IN PRIORITY STATUS

If an individual changes priority status after their initial request for services, the person is reassigned to the new priority status as of the date their status changed. The person is enrolled in chronological order based on the date of their change in Priority status. For example, if a Priority 2 person disenrolls from another Medicaid HCBS waiver, that person would become a Priority 1 individual. The person would receive an application with other Priority 1 individuals. The date he or she disenrolled from the other waiver would be considered the date of requested services for purposes of receiving an application. If a Priority 1 person enrolls in another waiver, that person would become a Priority 2 individual. If applications are sent to Priority 2 individuals, the person would receive an application with other Priority 2 individuals. The date he or she enrolled in the other waiver would be considered the date of requested services for purposes of receiving an application.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

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

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

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

Select one:

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

Specify percentage:

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

Specify:

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 spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- ☐ **Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

  Select one:

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

    (*select one*):

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

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

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

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

    Specify:

    [ ]
- ( ) **The following dollar amount**

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

  Specify:

  [ ]
- ( ) **Other**

  Specify:

  [ ]

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

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

Specify:

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

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

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

- ( ) **The amount is determined using the following formula:**

Specify:

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

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

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

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

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

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

Select one:

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

○ **The State does not establish reasonable limits.**
○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

Specify percentage:

○ **The following dollar amount:**

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

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

Specify formula:

○ **Other**

Specify:

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 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 an entity under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

Level of care evaluations may be conducted by any physician licensed in Pennsylvania under PA Code Title 49, Chapter 17.

If the physician indicates ICF/IID level of care, a Qualified Intellectual Disabilities Professional (QIDP) employed by ODP will evaluate whether the person meets ICF/ID level of care. If the physician indicates the person meets ICF/ORC level of care criteria, an additional assessment is not necessary.

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:

Qualified Intellectual Disabilities Professional (QIDP) must meet one of the following three criteria:

1. A Master's degree or above from an accredited college or university and one year of work experience working directly with persons with intellectual disabilities;
2. A Bachelor's degree from an accredited college or university and two year's work experience working directly with persons with intellectual 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 intellectual disabilities.

Physicians are not contracted with the state to perform level of care evaluations.

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.

ICF/ID criteria:
The ICF/ID level of care shall be indicated only when the applicant or recipient:
(1) Requires active treatment.
(2) Has a diagnosis of an intellectual disability.
(3) Has been recommended for an ICF/ID level of care based on a medical evaluation.

A diagnosis of an intellectual disability is documented by meeting the following requirements:
(1) A licensed psychologist, certified school psychologist or a licensed physician who practices psychiatry shall certify that the applicant or recipient has significantly sub-average intellectual functioning which is documented by one of the following:
(i) Performance that is more than two standard deviations below the mean as measurable on a standardized general intelligence test.
(ii) Performance that is slightly higher than two standard deviations below the mean of a standardized general intelligence test during a period when the person manifests serious impairments of adaptive behavior.
(2) A qualified intellectual disabilities professional as defined in 42 CFR 483.430 (relating to condition of participation: facility staffing) shall certify that the applicant or recipient has impairments in adaptive behavior as provided by a standardized assessment of adaptive functioning which shows that the applicant or recipient has one of the following:
(i) Significant limitations in meeting the standards of maturation, learning, personal independence or social responsibility of his age and cultural group.
(ii) Substantial functional limitation in three or more of the following areas of major life activity:
(A) Self-care.
(B) Receptive and expressive language.
(C) Learning.
(D) Mobility.
(E) Self-direction.
(F) Capacity for independent living.
(G) Economic self-sufficiency.
(3) It has been certified that documentation to substantiate that the applicant's or recipient's conditions were manifest before the applicant's or recipient's 22nd birthday, as established in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C.A. § 6001).

ICF/ORC criteria:

The ICF/ORC level of care shall be indicated only when the applicant or recipient:
(1) Requires active treatment.
(2) Has a diagnosis of another related condition.
(3) Has been recommended for an ICF/ORC level of care based on a medical evaluation.

Another related condition is defined as a severe disability, such as cerebral palsy, spina bifida, epilepsy or other similar condition manifest prior to age 22 that results in substantial limitations in at least three of the following six activities of daily living:

_ self-care,
_ receptive and expressive language

_ learning,
_ mobility,
_ self direction and/or
_ capacity for independent living

The Medical Evaluation form (MA 51) is used to determine level of care

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:

Applicants who have been determined by BAS Regional Office staff or contractors to meet program eligibility requirements specified in Appendix B-1 are evaluated by a physician using the Medical Assistance Evaluation form (MA51) to determine level of care.

If the MA51 indicates a person meets ICF/IID level of care criteria, BAS will assign a Qualified Intellectual Disabilities Professional (QIDP) to assess whether the person requires ICF/IID level of care using the criteria in B-6-d.

For initial evaluations, BAS Regional Office staff assist physicians with completing the MA51 when necessary. For reevaluations, Supports Coordinators assist physicians with this task when necessary.

This includes helping the participant to schedule the appointment with his/her physician, helping the participant to get to the appointment, reviewing the completed form to ensure that the physician completes the form accurately, answering the physician's questions, including the purpose of the form, and facilitating that the level of care form is shared with the support coordinator who keeps the original in the participant's file.

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:

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 BAS 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, BAS 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:

BAS maintains copies of all level of care evaluations and reevaluations.

The medical evaluation form date is logged in HCSIS and a hard copy is kept in the participant's file at each BAS regional office.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
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:
BAS'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**
☐ **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):
Record reviews, on-site
If 'Other' is selected, specify:
BAS paper review of MA51 forms

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.
BAS captures data regarding initial level of care (LOC) determination of 100% of waiver applicants in the Participant Tracking Database. That data is verified on a continuous and ongoing basis by comparing paper records of LOC to the data entered into the database. If a discrepancy is noted, BAS will correct it as necessary. BAS also reviews the paper records to ensure that the standard LOC determination instrument is used and the standard process is followed for all initial LOC determinations. If a deviation is noted, BAS will document the reason within the database.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Each quarter, BAS reviews information collected from the discovery activities during that quarter. BAS staff meet quarterly to discuss findings and identify remediation strategies if necessary. If there are multiple issues of performance, the BAS Director will set priorities regarding which issue to address first.

If the information indicates that there are issues in timely performance or in following the level of care process, BAS will first assess whether problems are system-wide or isolated to a particular provider or region.

If problems are system-wide, the BAS Director or a designee will meet with individuals involved in level of care issues, such as BAS staff and Supports Coordinators who assist physicians in completing the MA51 form. The meetings will identify systemic issues that lead to untimely performance or not following the process, and identify possible solutions such as staff training, technical assistance, more intensive monitoring, or process changes. The BAS Director or designee will then develop a quality improvement strategy to address the issue.

If performance issues are isolated to only one region or provider, the BAS Director or designee will communicate with the responsible DHS staff or provider to identify the reason for the issues in performance. In addition, BAS may interview participants, family members, and providers, and/or review additional records, as necessary. The BAS Director or designee will determine corrective action based on the data collected and the previous performance of the staff person or provider. Examples of corrective action include additional training, more intensive monitoring by BAS, follow-up and resolution through a corrective action plan. For performance issues with providers, BAS will follow DHS departmental policy regarding sanctions and, if warranted, termination of the provider 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).

BAS 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, BAS will send the participant a list of Supports Coordination Agencies. The participant will choose their Supports Coordination Agency with assistance from BAS 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, BAS 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 agency. A Service Delivery Preference Form documents the participant's 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 participant's record located at the Supports Coordination Agency.

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 DPW that will connect them to an interpreter service. The DPW Office of Administration, Bureau of Equal Opportunity, coordinates LEP issues for DPW 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. DPW 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, BAS contacts the DPW telephone interpreter service, which will translate the message and translate BAS' return of phone call.

The telephone interpreter service will translate for BAS staff in other phone calls to people with LEP. DPW will arrange for in-person translation services to translate in-person interviews by BAS 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. BAS 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, BAS 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**		

Service Type	Service		
Other Service	Nutritional Consultation		
Other Service	Specialized Skill Development		
Other Service	Temporary Supplemental Services		
Other Service	Transitional Work Services		
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. 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), Transitional Work Services, 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 Transitional Work Services 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 BAS 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 the Bureau of Autism Services (BAS) by the participant's Supports Coordinator on behalf of the participant, using a form designated by BAS.

Day Habilitation may not be provided in a licensed Adult Training Facility that enrolls on or after 3/17/19 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.

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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders, and meet the requirements of Title 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:
Bureau of Autism Services
Frequency of Verification:
Not more than 30 months

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 still be included in the ISP but the ISP team does not have to agree upon the modification.

The Residential Habilitation provider shall ensure that a room and board residency agreement, on a form specified by BAS, 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 (Group Settings) licensed under Title 55 Pennsylvania Code Chapter 6400; and
•Family Living Homes licensed under Title 55 Pennsylvania 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 Family Living Home.
Facility capacity is limited to four or fewer participants per Community Home.

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 BAS 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.

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	Family Living 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:
Family Living 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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders, and meeting all requirements of Title 55 PA Code Chapter 6500.

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Autism Services

Frequency of Verification:
Not more than 30 months

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):*
Community Home 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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders, and meet requirements of Title 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:

Bureau of Autism Services
Frequency of Verification:
Not more than 30 months

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	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 Transitional Work Services 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	Family Living 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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Autism Services

Frequency of Verification:
Not more than 30 months

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Family Living 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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Autism Services

Frequency of Verification:
Not more than 30 months

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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Autism Services
Frequency of Verification:
Not more than 30 months

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: 03 Supported Employment

Sub-Category 1: 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 BAS 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.

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, Transitional Work Services 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 BAS 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 Transitional Work Services 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, 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.

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):*

Other Standard *(specify):*
Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed Adult Autism Waiver Supplemental Provider Agreement.

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 all required training developed by the Bureau of Autism Services regarding services for people with autism spectrum disorders and have completed required vocational training developed or approved by the Bureau of Autism Services.

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Autism Services

Frequency of Verification:
Not more than 30 months

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

Service Definition *(Scope):*

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 BAS 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.
*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, the Supports Coordinator assists the participant's physician in completing the level of care re-evaluation as necessary.
* 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 BAS on the authorization of services on an ongoing basis and when BAS identifies issues with requested services
*Communicates the authorization status of services to ISP team members, as appropriate

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, BAS staff will perform the Supports Coordination tasks described in this waiver to assure health and welfare of the participant.

Supports Coordination Agencies 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 Agency may not provide any other waiver services for that individual. A Supports Coordination Agency which is enrolled as an Organized Healthcare Delivery System (OHCDS) may furnish Community Transition Services, Assistive Technology, Home Modifications and Vehicle Modifications. A participant's Supports Coordination Agency may not have a fiduciary relationship with providers of the participant's other services, except for Community Transition Services, Assistive Technology, Home Modifications and Vehicle Modifications. A participant's Supports Coordination Agency may not own or operate providers of Community Transition Services, Assistive Technology, Home Modifications, 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 Agency

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 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 Adult Autism Waiver Supplemental Provider Agreement.

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 or approved by the Bureau of Autism Services for Supports Coordination for people with autism spectrum disorders, including training in needs assessment and person-centered planning

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Autism Services

Frequency of Verification:

Not more than 30 months

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	T1006 counseling
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	T1100 speech, hearing, and language therapy
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*
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
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 Adult Autism Waiver Supplemental Provider Agreement.

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.

In addition, individuals providing these services must complete required training developed or approved by BAS regarding services for people with ASD.

Verification of Provider Qualifications
Entity Responsible for Verification:
BAS
Frequency of Verification:
Not more than 30 months

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 Adult Autism Waiver Supplemental Provider Agreement.

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.

In addition, individuals providing these services must complete required training developed or approved by BAS regarding services for people with ASD.

Verification of Provider Qualifications

Entity Responsible for Verification:
BAS

Frequency of Verification:
Not more than 30 months

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 Adult Autism Waiver Supplemental Provider Agreement.

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.

In addition, individuals providing these services must complete required training developed or approved by BAS regarding services for people with ASD.

Verification of Provider Qualifications

Entity Responsible for Verification:
BAS

Frequency of Verification:
Not more than 30 months

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 Adult Autism Waiver Supplemental Provider Agreement.

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.

In addition, individuals providing these services must complete required training developed or approved by BAS regarding services for people with ASD.

Verification of Provider Qualifications

Entity Responsible for Verification:
BAS
Frequency of Verification:
Not more than 30 months

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 Adult Autism Waiver Supplemental 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.

Verification of Provider Qualifications

Entity Responsible for Verification:
BAS
Frequency of Verification:
Not more than 30 months

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.

Verification of Provider Qualifications

Entity Responsible for Verification:
BAS

Frequency of Verification:
Not more than 30 months

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.

Verification of Provider Qualifications

Entity Responsible for Verification:
BAS

Frequency of Verification:
Not more than 30 months

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: 03 Supported Employment

Sub-Category 1: 03030 career planning

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
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 Transitional Work Services 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.

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 Vocational Assessment services; or
• Payments that are passed through to users of Vocational Assessment 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. BAS will review the reauthorization request and make a determination based on BAS policy. BAS 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. BAS will review the reauthorization request and make a determination based on BAS policy. BAS 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, BAS 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):*

Other Standard *(specify):*
Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed Adult Autism Waiver Supplemental Provider Agreement.

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:
A Bachelor's degree or higher in rehabilitation, business, or marketing; or
Have a Bachelor's degree in a field related to rehabilitation, business or marketing and 1 year of experience that can be verified related to job assessment, job finding or employment supports, or

A Bachelor's degree in Education, Psychology or other related social sciences and 1 year of experience that can be verified related to job assessment, job finding or employment supports; or
An Associate's degree in rehabilitation, business, marketing or field related to rehabilitation, business or marketing and 2 years of documented experience related to job assessment, job finding or employment supports; or
An Associate's degree or higher in any field and 5 years of experience that can be verified related to job assessment, job finding or employment supports;

Completion of required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders, including training in providing a situational vocational assessment.

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Autism Services

Frequency of Verification:
Not more than 30 months

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 Agencies
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 Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed Adult Autism Waiver Supplemental Provider Agreement.
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 agencies 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:
Bureau of Autism Services
Frequency of Verification:
Not more than 30 months

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 Adult Autism Waiver Supplemental Provider Agreement.
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:
Bureau of Autism Services
Frequency of Verification:
Not more than 30 months

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

Service Definition *(Scope):*

This service provides counseling and training for the participant's family and informal network to help develop and maintain healthy, stable relationships among all members of the participant's 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 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 Supports Coordinator will summarize monthly progress in the Quarterly Summary Report submitted into HCSIS. The Family Support provider must maintain monthly notes in the participant's file and have them available for review by BAS 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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Autism Services
Frequency of Verification:
Not more than 30 months

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 family living 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 BAS consistent with BAS 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.

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:
BAS

Frequency of Verification:
Not more than 30 months

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.

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:
BAS

Frequency of Verification:
Not more than 30 months

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 Adult Autism Waiver Supplemental Provider Agreement.

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:
BAS

Frequency of Verification:
Not more than 30 months

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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Autism Services

Frequency of Verification:
Not more than 30 months

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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Autism Services

Frequency of Verification:
Not more than 30 months

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. Initial BSP Development:

The Behavioral Specialist 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. BAS reviews the amount of direct and consultative service requested before authorization to ensure it is appropriate given the needs identified.

2. 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 BAS 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. 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. 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. 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. BAS 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. 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. 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. 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 to one participant, one direct support professional to two participants and one direct support professional 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 Transitional Work Services 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 BAS consistent with BAS policy.

Community Support may not be provided at the same time that quarter hourly-reimbursed Respite, Day Habilitation, Transitional Work Services, 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 BAS 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 Adult Autism Waiver Supplemental Provider Agreement;
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:

• 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 BAS or by an accredited college or university. If this training was not provided by the BAS, BAS must review and approve the course description.
•Complete required training developed by the BAS regarding Behavioral Specialist Services for people with ASD and other trainings required for the Behavioral Specialist Service.
•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 the BAS regarding Systematic Skill Building for people with ASD and other trainings required for the Systematic Skill Building service.
•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 all required training developed by the Bureau of Autism Services for people with ASD and other trainings required for the Community Support service.

Verification of Provider Qualifications

Entity Responsible for Verification:
BAS

Frequency of Verification:
Not more than 30 months

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 BAS 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.

BAS 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, BAS 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 BAS 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	Family Living 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:
Family Living 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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed by the Bureau of Autism Services regarding services for people

with autism spectrum disorders.
•If transporting participants, have a valid driver's license and automobile insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Autism Services

Frequency of Verification:
Not more than 30 months

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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed by the Bureau of Autism Services regarding services for people with autism spectrum disorders.
•If transporting participants, have a valid driver's license and automobile insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Autism Services

Frequency of Verification:
Not more than 30 months

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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed by the Bureau of Autism Services regarding services for people with autism spectrum disorders.
•If transporting participants, have a valid driver's license and automobile insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Autism Services

Frequency of Verification:

Not more than 30 months

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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed by the Bureau of Autism Services regarding services for people with autism spectrum disorders.
•If transporting participants, have a valid driver's license and automobile insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Autism Services

Frequency of Verification:
Not more than 30 months

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:
Transitional Work Services

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):*
Transitional Work Services 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. Transitional Work Services may not be provided in a facility subject to Title 55, Chapter 2380 or Chapter 2390 regulations. Transitional Work Services do 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.

Transitional work service options include: mobile work force, work station in industry, affirmative industry, and enclave.

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.

Transitional Work Services include 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.

Transitional Work 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, 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.

Transitional Work services may be provided without referring a participant to OVR unless the participant is under the age of 25. When a participant is under the age of 25, Transitional Work Services may only be authorized as a new service in the ISP when documentation has been obtained that OVR has closed the participant's case, has stopped providing services to the participant, or that the participant has been determined ineligible for OVR services.

Transitional Work Services 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 Transitional Work Services 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 BAS 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 Transitional Work services; or

• Payments that are passed through to users of Transitional Work 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	Transitional Work Services Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transitional Work Services

Provider Category:
Agency

Provider Type:
Transitional Work Services 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 Adult Autism Waiver Supplemental Provider Agreement.

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 required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.

The Transitional Work Services 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:
Bureau of Autism Services

Frequency of Verification:
Not more than 30 months

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

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

Service Definition *(Scope):*

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 BAS for consideration during BAS'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 family living host when the vehicle is not owned by the Family Living 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.

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:
BAS
Frequency of Verification:
Not more than 30 months

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.

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:
BAS
Frequency of Verification:
Not more than 30 months

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 Adult Autism Waiver Supplemental Provider Agreement.

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:
BAS

Frequency of Verification:
Not more than 30 months

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

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	☐
Transitional Work Services	☐
Nutritional Consultation	☐
Temporary Supplemental Services	☐
Supported Employment	☐
Day Habilitation	☐
Therapies	☐
Family Support	☐
Supports Coordination	☐
Vehicle Modifications	☐
Assistive Technology	☐

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	☐

Standard	Topic Addressed
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	☐
Specialized Skill Development	☐
Career Planning	☐
Respite	☐
Community Transition Services	☐
Home Modifications	☐
Transitional Work Services	☐
Nutritional Consultation	☐
Temporary Supplemental Services	☐
Supported Employment	☐
Day Habilitation	☐
Therapies	☐
Family Support	☐
Supports Coordination	☐
Vehicle Modifications	☐
Assistive Technology	☐

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	

Standard	Topic Addressed
	☐
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	☐
Transitional Work Services	☐
Nutritional Consultation	☐
Temporary Supplemental Services	☐
Supported Employment	☐
Day Habilitation	☐
Therapies	☐
Family Support	☐
Supports Coordination	☐
Vehicle Modifications	☐
Assistive Technology	☐

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.

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, BAS 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 participant's 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 participant's 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:

BAS developed provider informational materials, which have been widely distributed to providers and provider associations and are available upon request. BAS 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). BAS 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 BAS at any time with questions. Staff provide technical assistance to providers in preparing an enrollment application. If a provider applies, BAS staff determine whether the provider meets the provider qualification criteria outlined in this waiver. (Training required by BAS is available at no cost to the provider.) If the provider meets the criteria, BAS 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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
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 BAS/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 direct support professionals who meet age, education, experience, and criminal background check requirements per Appendix C prior to service delivery. Numerator = Number of DSPs who meet age, education, experience, and criminal background check requirements per Appendix C prior to service delivery. Denominator = Number of DSPs reviewed.

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

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 DSPs who completed required training. Numerator = Number of DSPs who completed required training. Denominator = Number of DSPs reviewed.

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
BAS reviews findings of the documentation review annually.

If findings from discovery activities indicate a provider does not meet provider standards, BAS will contact the provider for more information to assess whether the provider meets standards. If a provider does not meet provider standards, BAS will give the provider 30 days to remediate the reason for ineligibility. BAS will provide technical assistance and training to the provider during this time to prevent disenrollment. BAS will advise Supports Coordinators that the provider may be disenrolled and that a) participants may need to find new providers and b) Supports Coordinators must not include the provider in new ISPs during the 30 day period. If the provider is a Supports Coordination agency, BAS will notify participants that the provider may be disenrolled and that participants may need to find new providers. If the provider does not meet provider standards after 30 days, BAS will disenroll the provider and notify Supports Coordinators that participants will need to identify a new provider. The Supports Coordinator will notify the participant that a new provider is necessary. If the provider is a Supports Coordination agency, BAS will notify participants and assist them in choosing new Supports Coordination agencies. BAS will send a notice of action to the provider to let the provider know that it can appeal the disenrollment decision to the DPW Bureau of Hearings and Appeals. BAS may require the provider to refund some or all of the payments it has received.

If BAS identifies provider staff that do not meet provider standards, BAS will require the provider to specify whether it will assign different staff or perform tasks necessary for the staff to meet provider requirements (e.g., conduct a criminal background check or complete BAS-required training). Any tasks to enable staff to meet provider requirements must be completed within 30 days. BAS will provide technical assistance and training to the provider during this time. If the provider attempts to help the staff person meet qualifications, BAS will follow up with the provider after 30 days to ensure that the provider's attempts to have staff meet qualifications have been completed.

BAS also will notify the Supports Coordinator when provider staff does not meet provider standards. The Supports Coordinator will inform the participant that the provider staff did not meet qualifications and the planned corrective action. The Supports Coordinator will remind the participant that he or she may choose a different provider for the service. If the provider staff person that does not meet standards is a Supports Coordinator, BAS will inform the participant and remind the participant that he or she may choose a different provider. Following the process described in the Financial Accountability assurance, BAS may require the provider to refund some or all of the payments received for services provided by this staff person.

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 Transitional Work Services. (b) BAS 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 BAS by the participant's Supports Coordinator on behalf of the participant, on a form designated by BAS. (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 agencies 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. BAS 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 agency. BAS requires the Supports Coordination Agency to provide a document signed by the participant or his or her representative stating their understanding of the choice of providers available to them. BAS also reviews all ISPs to ensure that the needs

of the participant are being addressed and that providers other than Supports Coordination agencies 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 Agency
BAS offers the participant the choice of all enrolled Supports Coordination Agencies once the participant is determined eligible for the waiver and assists the participant with choosing a Supports Coordination Agency. The participant selects the Supports Coordination Agency 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, BAS 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 BAS'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 BAS:

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 Agency, 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 BAS for approval and authorization within 45 calendar days of selection of a Supports Coordination Agency. This timeframe may be extended for circumstances beyond the Support Coordinator’s control with prior approval from BAS.
(7) If BAS requests revisions of the ISP, resubmit the amended ISP for approval and authorization within 7 days of the date BAS 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 timelines specified in 55 Pa. Code §51.29(SCA requirements for Adult Autism Waiver):
(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 BAS for approval and authorization
(7) If BAS 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.

BAS is responsible to review, approve, and authorize the ISP in HCSIS within 15 calendar days of submission of the ISP to BAS. Once the ISP is approved and authorized, BAS 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, 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, BAS 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, BAS 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. BAS 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.

BAS 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. BAS 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. BAS 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 BAS's review of each ISP, BAS reviews the assessments used in the planning development process. This review includes confirming that the planning team identified and addressed assessed risks. If BAS 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 BAS staff with questions or concerns. When BAS is made aware of a risk, BAS 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, BAS 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. BAS 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.

BAS holds quarterly risk management meetings to discuss the status of individuals who are at risk and the response that is being implemented. If BAS determines that issues exist at a system level which may increase risk, BAS 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 Agency
BAS offers the participant the choice of all enrolled Supports Coordination Agencies once the participant is determined eligible for the waiver and assists the participant with choosing a Supports Coordination Agency. The participant selects the Supports Coordination Agency 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 Agencies 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, BAS 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. BAS 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 BAS for approval. BAS approves all ISPs within 15 days of the date the Supports Coordinator submits the ISP to BAS 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 BAS and enters the results of the monitoring into HCSIS. BAS 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 BAS 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. BAS uses HCSIS to monitor that Supports Coordinators are conducting required monitoring visits. BAS 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 agencies 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. BAS 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 Agency. 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. BAS 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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Performance Measure SP1: Number and percent of participants who have all documented needs and personal goals addressed in the ISP through waiver funded services or other non-waiver supports. Numerator = Number of participants who have all needs and personal goals addressed in the ISP through waiver funded services or other non-waiver supports. Denominator = Number of participants reviewed.

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

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:
		☐ **Other**

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

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

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

Performance Measure:
Performance Measure SP2: Number and percent of participants whose service plans are updated/revised at least annually and in response to a change in need. Numerator = Number of participants whose service plans are updated/revised at least annually and in response to a change in need. Denominator = Number of participants reviewed.

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

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

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 SP3: 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:
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 = 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:

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 SP4: Number and percent of participants for whom choices among waiver services and providers is documented. Numerator = Number of participants for whom choices among waiver services and providers is documented. Denominator = Number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
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. An individual is not able to receive waiver-funded services that are not in his or her ISP. As described in Appendix I, PROMISe and HCSIS system edits limit payments to waiver services specified in the participant's ISP. BAS staff review all ISPs before provision of services, and approve or request revisions to ISPs based on the ISP, Supports Coordinator notes, copies of the needs assessments specified in Appendix D-1-d(b), and copies of the forms specified in Appendix B-7-a to document the participant received a choice between waiver and institutional services and a choice among waiver providers.

Supports Coordinators monitor whether services were actually provided as part of the ISP monitoring described in Appendix D-2-a. Supports Coordinators must contact the participant at least each month and visit the participant in-person at least each quarter. 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 a participant receives services, if the services are furnished outside the home. The monitoring includes assessing the extent to which the participant is receiving waiver services and non-waiver services in the amount, duration, and frequency specified in his or her ISP. Supports Coordinators indicate in their notes in HCSIS if information suggests 1) a participant's utilization of waiver services is different from what has been authorized; and/or 2) a participant is not able to access non-waiver services as specified in the ISP.

In addition, BAS staff interview a sample of participants, and their provider staff, to assess the quality of services. BAS developed a standard template for these interviews, which includes questions regarding unmet needs and goals; the service planning process; participant choice of provider; participant choice between waiver and institutional services; and the amount, scope, and frequency of services provided.

BAS staff also review provider and Supports Coordinator documentation for these participants to identify indications of unmet needs and goals and of under- or over-utilization. The records include assessment instruments; the forms identified in Appendix B-7; Supports Coordinator notes; ISPs; critical incident reports; and providers' records of service delivery.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
After reviewing each service plan, BAS directs the Supports Coordinator to revise the ISP if 1) the ISP does not address all identified needs or goals; 2) it appears the Supports Coordinator did not follow the service planning process; or 3) there is insufficient documentation that the participant exercised his or her rights to choose among service providers and/or between waiver and institutional services. BAS may contact the participant and representative (if applicable) to investigate the situation. The Supports Coordinator must revise the ISP, reconvening the planning team and/or conducting assessments if necessary, and send the revised ISP to BAS for review within 7 days of the date it was returned to the Supports Coordinator for revision.

If an individual's ISP does not address all of an individual's needs, and services appear inadequate to assure the participant's health and welfare, BAS staff will require the Supports Coordinator to reconvene the planning team within 30 days to change the ISP. Similarly, if the service planning process was not followed and may affect participant's health and welfare, BAS staff will require the Supports Coordinator to reconvene the planning team within 30 days to review the ISP.

If a Supports Coordinator finds that a participant is not receiving the services authorized in his or her ISP, he or she will contact the provider(s), the participant and representative (if applicable) to identify the reason services were not delivered and address reasons for underutilization. The Supports Coordinator may revise the ISP if the participant at any time wishes to change providers. The Supports Coordinator may re-convene the ISP team to address underutilization. For example, if the participant finds he or she does not need the amount of services in the ISP, the Supports Coordinator and the ISP team may assess whether the amount of services in the ISP should be reduced.

At any point, if BAS determines that an individual was not able to freely exercise the right to choose 1) between waiver and institutional services, or 2) among service providers; BAS will contact the participant to ensure they are aware of their right to choose between waiver and institutional services or among service providers. BAS may assist the individual in finding a new Supports Coordinator or Supports Coordination Agency if necessary or desired. If the person prefers institutional services, BAS must identify available institutions for the individual.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 BAS 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 BAS, 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.

BAS 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 Bureau of Autism Services (BAS)

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).

BAS 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. BAS 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 BAS for resolution and that resolution is entered into the database. BAS will resolve complaints within 30 calendar days and the participant will be notified in writing of the resolution.

BAS 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).

BAS articulated the incident management policy described below in a provider manual for all providers and a manual specifically for supports coordinators. All Adult Autism Waiver providers must follow this policy.

Types of incidents that must be reported:

Incidents to be reported within 24 hours

Most incident categories are reported using a standardized incident report that is comprised of two components, the first section and the final section. The first section must be submitted within 24 hours of the occurrence or discovery of the incident or within 72 hours of the occurrence or discovery of a medication administration error incident. The first section of the incident report includes individual and provider demographics, incident categorization, actions taken to protect the health and safety of the individual, and a description of the incident. The final section of the incident report must be submitted within 30 days of the incident's recognition or discovery, and must contain all of the information from the

first section as well as additional specific information relevant to the incident. If the provider agency determines it will not be able to meet the 30-day reporting timeframes for completion of the final section, notification of an extension is to be made to BAS staff prior to the expiration of the 30-day period.

Providers must submit all incidents within the Enterprise Incident Management (EIM) system. EIM enables prompt notification of BAS and the Supports Coordinator.

If EIM is unavailable, providers must complete and e-mail incident reports using a password-protected Excel form developed by BAS. 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, BAS staff will notify supports coordinators of critical incidents for the people they serve via telephone and/or e-mail of password protected files.

In Appendix G-1-d, BAS specifies the types of incidents that must be investigated. The entity that reports an incident – whether a provider, a SC agency, or BAS – must identify a certified investigator to conduct required investigations promptly. A certified investigator is a person who has been trained and received a certificate in investigation from ODP. All enrolled providers are required to either have a certified investigator on staff or contract with a certified investigator. Certified investigators are responsible to investigate incidents as per their standard training, and to complete an Incident Report with a summary of their investigation findings. Corrective action for the incident must address any investigation findings.

The following are categories of incidents to be reported within 24 hours using a standardized incident report:

1. Abuse - The allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Abuse is reported from the victim's perspective, not from the perspective of the person committing the abuse.
(i) 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, applying noxious or potentially harmful substances or conditions to an individual.
(ii) Psychological abuse– An act, other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.
(iii) 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.
(iv) Verbal abuse – A verbalization that inflicts or may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.
(v) Improper or unauthorized use of restraint – A restraint not approved in the ISP 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.
2. Death – All deaths are reportable.
3. Disease Reportable to the Department of Health – An occurrence of a disease on The Pennsylvania Department of Health List of Reportable Diseases. The current list can be found at the Department of Health's website, www.health.state.pa.us. An incident report is required only when the reportable disease is initially diagnosed.
4. Emergency closure – An unplanned situation that results in the closure of a home or program facility for one or more days. This category does not apply to individuals who reside in their own home or the home of a family member. (This may be reported as a site report, which is a report related to multiple participants receiving services at the same place.)
5. Emergency room visit – The use of a hospital emergency room. This includes situations that are clearly "emergencies" as well as those when an individual is directed to an emergency room in lieu of a visit to the Primary Care Physician (PCP) or as the result of a visit to the PCP. The use of an emergency room by an individual's PCP, in place of the physician's office, is not reportable.
6. Fire – A situation that requires the active involvement of fire personnel that is extinguishing a fire, clearing smoke from the premises, responding to a false alarm, and the like. Situations which require the evacuation of a facility in response to suspected or actual gas leaks and/or carbon monoxide alarms, or both, are reportable. Situations in which staff extinguish small fires without the involvement of fire personnel are reportable. This may be reported as a site report.
7. Hospitalization – An inpatient admission to an acute care facility for purposes of treatment. Scheduled treatment of medical conditions on an outpatient basis is not reportable.
8. Individual-to-individual abuse – An interaction between one individual receiving services and another individual receiving services resulting in an allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Individual-to-individual abuse is reported on from the victim's perspective, not on the person committing the abuse.
9. Injury requiring treatment beyond first aid – Any injury that requires the provision of medical treatment beyond that traditionally considered first aid. First aid includes assessing a condition, cleaning an injury, applying topical

medications, applying a Band-Aid, and the like. Treatment beyond first aid includes but is not limited to lifesaving interventions such as CPR or use of the Heimlich maneuver, wound closure by a medical professional, casting or otherwise immobilizing a limb. Evaluation/assessment of an injury by emergency personnel in response to a "911" call is reportable even if the individual is not transported to an emergency room.
10. Law enforcement activity – The involvement of law enforcement personnel is reportable in the following situations:
(i) An individual is charged with a crime or is the subject of a police investigation that may lead to criminal charges.
(ii) An individual causes an event, such as pulling a fire alarm that requires active involvement of law enforcement personnel, even if the event will not lead to criminal charges.
(iii) An individual is the victim of a crime, including crimes against the person or their property.
(iv) A crime, such as vandalism or a break-in, that occurs at a provider site. This may be reported as a site report.
(v) An on-duty employee or an employee who is volunteering during off duty time, who is charged with an offense, a crime or is the subject of an investigation while on duty or volunteering. This is reported as a site report.
(vi) A volunteer who is charged with an offense, a crime or is the subject of an investigation resulting from actions or behaviors that occurred while volunteering. This is reported as a site report.
(vii) A crisis intervention involving police/law enforcement personnel.
(viii) A citation given to an agency staff person for a moving violation while operating an agency vehicle, or while transporting individuals in a private vehicle, is reported as a site report.
11. Missing person – A person is considered missing when they are out of contact with staff for more than 24 hours without prior arrangement or if they are in immediate jeopardy when missing for any period of time. A person may be considered in "immediate jeopardy" based on the person's personal history and may be considered "missing" before 24 hours elapse. Additionally, it is considered a reportable incident whenever the police are contacted about an individual and/or the police independently find and return the individual, or both, regardless of the amount of time the person was missing.
12. 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 ISP 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.
13. Neglect – 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.
14. Psychiatric hospitalization – An inpatient admission to a psychiatric facility, including crisis facilities and the psychiatric departments of acute care hospitals, for the purpose of evaluation and/or treatment, or both, whether voluntary or involuntary. This includes admissions for "23 hour" observation and those for the review and/or adjustment, or both, of medications prescribed for the treatment of psychiatric symptoms or for the control of challenging behaviors.
15. 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 but are not limited to, 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.
16. Suicide attempt – The intentional and voluntary attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include suicidal threats.
17. Crisis Event – Atypical behavior for the participant that has escalated to the point where there is a risk of serious harm to self or others or damage to property exhibited in an environment that is not accommodating to the behavior and the behavior has not been responsive to minimal intervention and could result in law enforcement involvement, hospitalization of the participant or other undesired outcomes.
18. Restraints - Any physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or portion of the individual's body, including those that are approved as part of an ISP or those used on an emergency basis. Improper or unauthorized use of restraint is considered abuse and is to be reported under the abuse category.

Incidents to be reported within 72 hours

The following category of incidents must be reported within 72 hours of the recognition or discovery of the event:

1. Medication error – Any nonconforming practice with the Rights of Medication Administration" as described in the ODP Medication Administration Training Course. This includes omission, wrong dose, wrong time, wrong person,

wrong medication, wrong route, wrong position, wrong technique/method and wrong form.

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 BAS 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 BAS using the incident reporting methods described below. The supports coordination agency 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 BAS using the incident reporting methods described below and the supports coordination agency will assign a certified investigator if necessary according to Appendix G-1-d.

- Bureau of Autism Services

In some circumstances, BAS staff may be required to report incidents. BAS 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 entities compromises objectivity.

Incident Reporting Methods

The primary method used to report incidents is EIM as described above. If EIM functionality is unavailable, the methods for reporting an incident are by fax or an e-mail to BAS of the password-protected incident management forms described above.

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.

When Supports Coordinators meet with the participant and his/her family or representative for the introductory meeting and subsequent ISP development meetings, Supports Coordinators must review what participants, or anyone in the participant’s support team, should do if they have concerns about abuse, neglect, or exploitation and provide instructions for how to report these concerns to the Supports Coordinator or to the BAS toll-free number.

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:

BAS evaluates all incident reports within 24 hours of their submission to determine that appropriate action to protect the individual’s health, safety and rights occurred. If the appropriate actions have not taken place, BAS staff immediately communicate their concerns to the reporting entity (i.e., provider or supports coordinator). BAS approval of incidents must meet criteria within the Incident Management Closure Protocol.

After the provider or supports coordinator submits the final section of the Incident Report, BAS staff perform a management review within 30 days. BAS conducts the management review process so that at least 90 percent of the submitted incident reports are approved or not approved within 30 days of finalization by the provider or supports coordination entity. The management review process is to review the full report and approve or not approve the incident report. This process includes a determination that: (1) The appropriate action to protect the individual's health, safety and rights occurred. (2) The incident categorization is correct. (3) A certified investigation occurred when needed. (4) Proper safeguards are in place. (5) Corrective action in response to the incident has, or will, take place.

Entities responsible for conducting investigations and how investigations are conducted:

Investigations are required for the following categories of incidents defined in Appendix G-1-b:

- o Abuse
- o Death, when an individual is receiving services from a provider as specified in items 1-3 below.
- o Misuse of Funds
- o Neglect
- o Rights Violation
- o Hospitalization, when caused by one of the following:
  - o accidental injury,
  - o unexplained injury,
  - o staff to individual injury,
  - o injury resulting from individual to individual abuse, or
  - o injury resulting from restraint
- o Emergency room visit, when caused by one of the following:
  - o unexplained injury,
  - o staff to individual injury,
  - o injury resulting from individual to individual abuse, or
  - o injury resulting from restraint
- o Injury requiring treatment beyond first aid, when caused by one of the following:
  - o staff to individual injury,
  - o injury resulting from individual to individual abuse, or
  - o injury resulting from restraint
- o Individual to individual abuse, when sexual abuse is alleged

Providers are responsible for investigating the above types of incidents if the alleged incident occurred when 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 was 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.

Supports Coordinators are responsible for investigating events that can be categorized as abuse or neglect if the provider is not responsible as specified in items 1- 3 above. Also, if a provider's certified investigator 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 responsible for the investigation.

BAS is responsible for investigating events that BAS must report as specified in Appendix G-1-b. For incidents that the provider must investigate, BAS conducts a separate investigation for incidents that involve either death or the use of restraint.

The responsible entities identified above will assign certified investigators to conduct investigations. A certified investigator is a person who has been trained and received a certificate in investigation from ODP as communicated via Mental Retardation Bulletin 00-04-11, issued September 16, 2004, titled Announcement of Certified Investigations. Certified investigators are to promptly begin an investigation, when assigned, and are to enter a summary of their investigation findings in the Incident Report.

How investigations are conducted:

Certified investigators conduct their investigations as per their Certified Investigator training, by conducting face-to-face interviews with the alleged victim, interviewing witnesses, reviewing witnesses' written statements, determining whether clinical input is needed (if so the BAS Clinical Team would be contacted), securing that input, and identifying and reviewing other evidence as appropriate.

Certified investigators are required to complete investigation records and enter the summary of the investigator's findings into EIM. If EIM is unavailable, certified investigators must e-mail findings to BAS using a password-protected Excel form developed by BAS and investigators must e-mail the password separately to protect participant confidentiality. The summary is the compilation of the analysis and findings section of the investigation report. More information on the investigation report, is found in the Pennsylvania Certified Investigation Manual.

Investigation timeframes:

Investigation findings are part of final section of the incident report, mentioned in Appendix G-1-b, which must be submitted within 30 days of the incident's recognition or discovery. If the provider agency determines they will not be able to meet the 30-day reporting timeframes for completion of the final section, the provider must notify BAS prior to the expiration of the 30-day period.

Process and timeframes for informing the participant and his/her family and providers of the investigation results:

The provider point person must notify the participant and his or her family or representative of the occurrence of a reportable incident within 24 hours of the incident, or 72 hours for medication errors, unless otherwise indicated in the ISP. The provider point person must notify the participant and his/her family or representative of the findings of any investigation unless otherwise indicated in the ISP. BAS, Supports Coordinators, and provider staff, including staff from providers not involved in the incident, must be notified of the investigation results through EIM. If EIM is unavailable, point persons must e-mail findings to BAS using a password-protected Excel form developed by BAS. Point persons must e-mail the password separately to protect participant confidentiality.

Process and timelines for investigations findings that are not completed within 30 days:

Final reports that are not completed within 30 days will trigger a Plan of Correction (or Corrective Action Plan). The plan of correction requires the provider to submit the final incident report as promptly as possible. Timelines are established on a case-by-case basis based on the nature of the incident and the reason the final report was not submitted on time. The state will follow-up with the provider on investigation findings within one week of the passage of the 30-day deadline and at least monthly thereafter until findings are complete and any corrective action has been implemented.

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.

BAS is responsible for the oversight of and response to critical incidents. If the provider is licensed, BAS 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.

Within 24 hours of the submission of the first section of the incident report, BAS staff review the incident to determine that appropriate action to protect the individual's health, safety, and rights occurred. In the event that the appropriate actions have not taken place the BAS staff should immediately communicate their concerns to the appropriate provider or supports coordinator.

After the provider or supports coordinator submits the final section of the incident report, BAS completes a management review within 30 days. The management review process is to review the full report and approve or not approve the incident report. This process includes a determination that:
• The appropriate action to protect the individual's health, safety, and rights occurred.
• The incident categorization is correct.
• A certified investigation occurred when needed.
• Proper safeguards are in place.
• Corrective action in response to the incident has, or will, take place.

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.

BAS 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.

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).

BAS is clear on its mission to eliminate restraints as a response to challenging behaviors. BAS 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 (Title 55 PA Code, Chapters 2380, 6400, and 6500). Physical, chemical, and mechanical restraints are permitted only when consistent with the practices described below.

Use of Alternative Methods before Instituting Restraints

Waiver service providers should pursue alternative strategies to the use of restraint. Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restraints. If the person receives Behavioral Support Services, the participant's behavioral support plan and crisis intervention plan identifies specific interventions tailored to the individual that anticipate and de-escalate challenging behaviors before restraints are considered necessary. Restraining a person in a prone position is prohibited.

Protocols for When Restraints are Employed

Restraints are always a last resort to protect an individual's health and/ or safety. Consequently, restraints are never to be used as a punishment, therapeutic technique or for staff convenience. The participant must be immediately released from the restraint as soon as it is determined that the participant is no longer a risk to him/herself or others. Manual restraint shall be used only when it has been documented that other less restrictive methods have been unsuccessful in protecting the participant from injuring him/herself or others. For each participant for whom restrictive procedures – including restraints – may be used, a restrictive procedure plan shall be written prior to the use of restrictive procedures. The restrictive procedure plan shall include methods for modifying or eliminating the behavior, such as changes in the participant's physical and social environment, changes in the participant's routine, improving communications, teaching skills and reinforcing appropriate behavior.

The restrictive procedure plan shall be developed and revised by provider staff including participation of the individual's direct care staff, the behavioral specialist (if Behavioral Specialist Services are in the participant's ISP), and other professionals as appropriate. The restrictive procedure plan shall be submitted to the Supports Coordinator, who may convene the ISP team if necessary to discuss the plan. If the participant has a Behavioral Support Plan (BSP) and a Crisis Intervention Plan (CIP) which includes restrictive procedures, the BSP/CIP may serve as the restrictive procedure plan. The BSP and CIP are incorporated into the participant's ISP, and therefore, any restrictive procedure plan which is part of the BSP or CIP is also included in the ISP.

The restrictive procedure plan shall include:
(1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior.
(2) The single behavioral outcome desired stated in observable or measurable terms.
(3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and

social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing alternative appropriate behavior.
(4) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.
(5) A target date for achieving the outcome.
(6) The amount of time the restrictive procedure may be applied.
(7) Physical problems that require special attention during the use of restrictive procedures.
(8) The name of the staff person responsible for monitoring and documenting progress with the plan.

The restrictive procedure plan shall be implemented as written. Supports Coordinators and providers who developed the plan shall keep copies of the restrictive procedure plan in the individual's record. Providers who use restraints as part of their operating procedures must have a restrictive procedure review committee. This committee must review and revise (if necessary) the restrictive procedure plan at least every 6 months.

Methods for Detecting Unauthorized use of Restraints or Seclusion

As articulated in Appendix G-1, BAS defines the unauthorized use of physical, chemical, or mechanical 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.

Education and Training Requirements for Personnel who Administer Restraints and Seclusion

BAS has several resources available to providers to educate and train staff regarding the safe use of restraint and the reduction and elimination of restraints. A list of training resources is found in ODP Bulletin 00-06-09 Elimination of Restraints through Positive Practice.

BAS requires providers who administer restraints to submit their planned staff training curricula for review and approval. BAS validates implementation of staff training as part of provider monitoring

Training
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.

All staff should have initial training within 30 calendar days after their first day of employment and prior to working directly with an individual, or have documented training that has occurred within the past 12 months. Ongoing training is expected to occur within every calendar year. Training in the application of restraints is needed only for those providers who utilize restraint as part of their operating procedures. The following curriculum of training is required for those providers who utilize restraints.
•Environmental design and social, physiological, and cultural motivators for behavior, including information on individuals who have experienced trauma such as abuse. This includes understanding the impact of

environmental factors and triggers.
•Positive behavioral support methods that include techniques to de-escalate behavior; listening and communication skills; teaching functionally equivalent replacement behaviors; awareness of environmental factors that can cause disruptive behaviors; violence prevention and conflict resolution; and how to complete a FBA.
•Information on "best practice" methods for interacting with individuals who have a dual diagnosis of ASD and a mental illness. This includes the effects of medications, how medication changes can impact behavior, and teaching alternative strategies and other coping mechanisms.
•Person-centered alternatives to the use of restraint, including an understanding of which positive behavior supports are most effective with particular individuals and teaching strategies that emphasize prevention of future challenging incidents. This includes the integration of effective behavioral supports.
•Basic training in body mechanics that illustrates how to avoid hyperextensions and other positions that may endanger individual safety.
•Awareness of an individual's health history in order to assess increased risk that may occur during the application of a restraint.
•The use of physical restraints, including the proper application of restraints appropriate to the age, weight, and diagnosis of the individual. Also, the possible negative psychological effects of restraint, and monitoring an individual's physical condition for signs of distress or trauma.
•Definitions of restraint; policies on the use of restraints; the risks associated with the use of restraints; and staff experience the use of physical restraint applies to themselves. This includes debriefing techniques with the individuals they support as well as staff members.

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:

BAS is responsible for oversight of the use of restraints. BAS analyzes data on restraint as part of the regular analysis of incident data described in Appendix G-1. BAS 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. BAS will require corrective action if necessary. BAS will review individual occurrences of the use of restraints within 24 hours of occurrence. BAS 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.

DHS encourages use of positive behavioral supports and discourages restrictive interventions. BAS 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 (Title 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. Every attempt should be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than 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 of 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 family (staff persons), 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.

Protocols for When Restrictive Interventions are Employed

For each participant for whom restrictive interventions may be used, a restrictive intervention plan shall be written prior to the use of restrictive intervention. The restrictive intervention plan shall include methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing appropriate behavior. The restrictive intervention plan shall be developed and revised by provider staff including participation of the individual's direct care staff, the behavioral specialist (if Behavioral Specialist Services are in the participant's ISP), and other professionals as appropriate. The restrictive intervention plan shall be submitted to the Supports Coordinator, who may convene the ISP team if necessary to discuss the plan. If the participant has a Behavioral Support Plan (BSP) and a Crisis Intervention Plan (CIP) which includes restrictive interventions, the BSP/CIP may serve as the restrictive intervention plan.

The restrictive intervention plan shall include:

(1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior.
(2) The single behavioral outcome desired stated in observable or measurable terms.
(3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing alternative appropriate behavior.
(4) Types of restrictive interventions that may be used and the circumstances under which the interventions may be used.
(5) A target date for achieving the outcome.
(6) The amount of time the restrictive intervention may be applied.
(7) Physical problems that require special attention during the use of restrictive interventions.
(8) The name of the staff person responsible for monitoring and documenting progress with the plan.

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. Providers who use restrictive interventions as part of their operating procedures must have a restrictive intervention review committee. This committee must review and revise (if necessary) the restrictive intervention plan at least every 6 months. 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.

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.

Education and Training Requirements for Personnel who Administer Restrictive Interventions

ODP has several resources available to providers to educate and train staff regarding the reduction and elimination of restrictive interventions. A list of training resources is found in ODP Bulletin 00-06-09 Elimination of Restraints through Positive Practice.

BAS requires providers who administer restrictive interventions to submit their planned staff training curricula for review and approval. BAS validates implementation of staff training as part of provider monitoring.

Training

All staff should have initial training within 30 calendar days after their first day of employment and prior to working directly with an individual, or have documented training that has occurred within the past 12 months. Ongoing training is expected to occur within every calendar year. Training in the application of restrictive interventions is necessary only for those providers who utilize these interventions as part of their operating procedures. The following curriculum of training is required for those providers who utilize restrictive interventions:
•Environmental design and social, physiological, and cultural motivators for behavior, including information on individuals who have experienced trauma such as abuse. This includes understanding the impact of environmental factors and triggers.
•Positive behavioral support methods that include techniques to de-escalate behavior; listening and communication skills; teaching functionally equivalent replacement behaviors; awareness of environmental factors that can cause disruptive behaviors; violence prevention and conflict resolution; and how to complete a Functional Behavioral Assessment.
•Information on "best practice" methods for interacting with individuals who have a dual diagnosis of ASD and a mental illness. This includes the effects of medications, how medication changes can impact behavior, and teaching alternative strategies and other coping mechanisms.
•Person-centered alternatives to restrictive interventions, including an understanding of which positive practices are most effective with particular individuals and teaching strategies that emphasize prevention of future negative incidents. This includes the integration of effective behavioral supports.
•Awareness of an individual's health history in order to assess increased risk that may occur during the application of a restrictive intervention.
•Definitions of restrictive interventions; policies on the use of restrictive interventions; and the risks associated with these interventions. This includes debriefing techniques with the individuals they support as well

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:

BAS is responsible for oversight of the use of restrictive interventions. BAS analyzes data on restrictive interventions as part of the regular analysis of incident data described in Appendix G-1. BAS 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 restrictive interventions. BAS will require corrective action if necessary. BAS will review individual occurrences of the use of restrictive interventions within 24 hours of occurrence. BAS staff meet quarterly to review aggregated data, discuss trends, identify possible causes of trends and specify next steps for eliminating inappropriate use of restrictive interventions.

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:

BAS is responsible for detecting the unauthorized use of seclusion. BAS analyzes data on seclusion as part of the regular analysis of incident data described in Appendix G-1. BAS 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 of seclusion. BAS will require corrective action if necessary. BAS 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):

BAS is responsible for detecting the unauthorized use of seclusion. BAS analyzes data on seclusion as part of the regular analysis of incident data described in Appendix G-1. BAS 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 of seclusion. BAS will require corrective action if necessary. BAS will review individual occurrences of the use of seclusion within 24 hours of occurrence.

When BAS discovers a provider is using seclusion, providers must stop the practice within one business day. BAS has behavioral management experts who will assist the provider in developing positive interventions to use in place of seclusion.

○ **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, BAS reviews a sample of individual records, including medications. BAS also reviews incident reports related to medication errors, along with other incidents data as specified in Appendix G-1. Through ODP, BAS has access to nurses who help with questions about medications and responses. BAS 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, BAS reviews a sample of individual records, including medications. BAS also reviews incident reports related to medication errors, along with other incidents data as specified in Appendix G-1. Through ODP, BAS has access to nurses who help with questions about medications and responses. BAS requires corrective action if necessary.

BAS 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. BAS will review licensing reviews as part of annual provider monitoring.

Through OMAP oversight, FFS and 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 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 participant's 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 person's prescribed medications on the log to those available to be given. Observations of medication passes are required on an annual basis. Clinical nursing staff 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 BAS via an electronic database (EIM), which is accessible by the Supports Coordinator, and providers. If EIM functionality is unavailable, errors are reported to BAS 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 BAS 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 BAS 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, BAS reviews a sample of individual records, including medications. BAS also reviews incident reports related to medication errors, along with other incidents data as specified in Appendix G-1. Through ODP, BAS 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 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.

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, 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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Performance Measure PS1: 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**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Performance Measure PS2: 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:
Provider monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = 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 PS3: Number and percent of investigated incidents where the provider's corrective action plan (CAP) includes strategies to mitigate/prevent future incidents. Numerator = Number of incidents where the provider's CAP includes strategies to mitigate/prevent future incidents. Denominator = All investigated incidents where the provider is required to develop a CAP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Incident Management (EIM)and IM 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 PS4: Number and percent of participants with a confirmed incident which are reported and reviewed at quarterly risk management meetings to determine any patterns related to participants or providers. Numerator = Participants with a confirmed incident which are reported to quarterly risk management meetings. Denominator = All confirmed incidents.

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

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

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

Data Aggregation and Analysis:

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

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 PS5: Number and percent of incidents related to restrictive interventions where BAS policies and procedures were followed. Numerator = Number of incidents related to restrictive interventions where BAS policies and procedures were followed. Denominator = Number of incidents related to restrictive interventions.

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 PS6: Number of percent of participants who reported that they are able to receive medical attention as needed. Numerator = Number of participants who reported that they are able to receive medical attention as needed. Denominator = Number of participants interviewed.

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

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. As described in Appendix D-2-a. Supports Coordinators must contact the participant at least each month and visit the participant in-person at least each quarter. Within each year, at least one visit must occur in the participant's home and one visit must occur in a location outside the home where a participant receives services. Supports Coordinators enter monitoring findings in HCSIS. The monitoring includes:

• Observing whether the participant feels healthy and not in pain or injured;
• Interviewing the participant and others to identify any concerns regarding the participant's health and welfare;
• Reviewing the participant's progress toward goals; and
• Assessing the effectiveness of back-up plans.

BAS staff will review Supports Coordinator monitoring notes in HCSIS for certain participants. BAS conducts these reviews on a quarterly basis for participants who exhibited very serious or extremely serious challenging behaviors according to the most recent SIB-R assessment, or who have experienced a crisis episode in the past year.

All incidents are reported in EIM – or, if EIM is unavailable, via e-mail of password protected files as described in Appendix G-1-b. Each month, BAS generates reports regarding critical incidents. One report lists the participants that had a reported incident, the incident date and location, the type of incident, and status of investigation (if required). A second report shows similar information, but is organized by provider so BAS staff can quickly identify providers with an unusually high number of incidents. The third report shows the number of incidents by type of incident.

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, BAS will contact the supports coordinator, the participant, the provider(s) or other individuals as appropriate to determine necessary follow-up actions to reduce the risk of recurrence.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
As described in Appendix D-2-a, if at any point the Supports Coordinator believes that a participant's health and welfare is in jeopardy, he or she will 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 other service providers to address the issue.

If BAS identifies any concerns regarding health and welfare when reviewing Supports Coordination quarterly monitoring, BAS staff will provide support or technical assistance to the Supports Coordinator to help resolve the situation. When necessary, the Supports Coordinator will reconvene the planning team to revise the ISP. BAS staff may also contact the participant and/or other service providers as necessary to ensure participant health and welfare.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Within four months of the end of each State Fiscal Year (each October), BAS Central Office will produce an Annual Quality Assurance Report with a summary of findings and corrective action from all quality management activities described in the waiver application. The primary audience for both reports is the public, including people with ASD, advocacy groups, and providers. The report will be posted on the DHS Web site and available to the public. Based on information from the annual reports, the BAS Director will set priorities regarding quality improvement activities each year.

In addition, BAS Central Office leads quarterly Quality Management meetings attended by the supervisors of each BAS Regional Office. These meetings focus on reviewing aggregated provider and participant monitoring data, designing improvement projects to respond to identified needs for remediation, and tracking progress on

completion and effectiveness of improvement projects.

Specific to assuring health and safety, BAS staff will meet quarterly regarding risk management. The meetings will include a representative from the BAS Central Office, each BAS Regional Office, and the BAS clinical team. Before each meeting, BAS will review 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. BAS staff will 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 will discuss identified trends, identify possible causes, and specify next steps for reducing participants' risk of abuse, neglect, or exploitation.

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.

BAS will monitor system design changes on an annual basis and during quarterly Quality Management meetings as described in Appendix H.1.a.i. When system design changes are made, BAS will specify discovery activities and measures specific to the particular design change to evaluate the effect of the changes. BAS will then include the results in the Annual Quality Assurance Report. These reports will be communicated as described in Appendix H.1.a.i.

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

On an annual basis, BAS will evaluate the quality improvement strategy related to provider and participant monitoring. Once the annual monitoring cycle is completed, BAS reviews and analyzes the collected data to determine whether additional or improved tools or strategies are required for the next monitoring cycle. For quality issues not related to provider and participant monitoring, BAS holds quarterly Quality Management meetings to review and analyze data related to the day-to-day performance of the waiver. When weaknesses are identified, BAS staff develop improvement projects to address them. Before submission of a waiver renewal application, BAS solicits feedback from all waiver stakeholders on the waiver application as a whole, which includes the proposed quality improvement strategy. Stakeholder comments are considered prior to submission of the application.

BAS will work internally to draft suggested revisions of the quality improvement strategy, if any. BAS will then release a draft revision of the quality improvement strategy on the DHS Web site, noting any changes and BAS will solicit public comment from all interested parties. BAS will provide notice of changes to the quality improvement strategy through publication in the Pennsylvania Bulletin, distribution to BAS's provider listservs, advocacy organizations, support groups, and the Autism Services, Education, Resources and Training Collaborative (ASERT), an initiative funded by BAS that provides streamlined access to information to individuals with autism and those who support them.
BAS will consider comments from stakeholders and then release a final quality improvement strategy before submitting a waiver renewal to CMS during the fifth year of the waiver renewal (2021).

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) For a random sample of participants, as part of the annual monitoring of providers, BAS compares paid claims data to provider records such as time sheets and reports of services rendered. This review is described in the Performance Measure for Appendix I. This review is an on-site, manual comparison of a provider's records to a report of paid claims from PROMISe, the state's Medicaid Management Information System. BAS reviews for consistency of day and time between the documentation and the claim as well as documentation supporting the number of units billed. The review occurs each year for the providers serving the sample of participants, claims will be reviewed sufficient for a 95% confidence interval with 5% margin of error.

The providers who are currently serving the participants in the monitoring sample 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 BAS staff suspect inappropriate billing based on its monitoring, BAS 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 BAS monitoring and training of provider staff in documentation of services rendered;
o A time-limited monitoring by BAS 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, BAS 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.

BAS 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, BAS works with the provider to find the appropriate resolution to the issues found and remediate to avoid repetition in the future. The DHS 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 BAS post-payment reviews that ensure the adequacy and the integrity of payments:

In addition to the audits described above, BAS compares paid claims data to provider records such as time sheets and reports of services rendered for a random sample of participants. This review is described in the Performance Measure for Appendix I. This review is an on-site, manual comparison of a provider's records to a report of paid claims from PROMISe, the state's Medicaid Management Information System. BAS reviews for consistency of day and time between the documentation and the claim as well as documentation supporting the number of units billed. The review occurs each year for a sample of participants sufficient for a 95% confidence internal with 5% margin of error.

The providers who are currently serving the participants in the monitoring sample will have claims reviewed for a 95% confidence internal with a 5% margin of error by randomly selecting claims from the previous fiscal year across all participants served.
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 BAS for review. BAS 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, BAS 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 BAS. 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 BAS.

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.

BAS 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.

Annual provider monitoring includes a review of provider records for each participant in the random sample. During provider monitoring, BAS staff review documentation that substantiates that each service was provided as billed. If there is not adequate documentation or the monitor suspects' inappropriate billing, an expanded review will be initiated. For findings of noncompliance, a plan of correction is required and the inadequate billing would be adjusted or voided in PROMISe. If the provider is noncompliant with the plan of correction, or the BAS monitor discovers the provider is significantly out of compliance, the case is referred to BFO for an in-depth audit.

BAS verifies qualifications of every provider for each of the services for which they are enrolled on a biennial basis. In addition, providers supporting participants included in the annual monitoring of a statistically representative sample are also monitored for qualifications, compliance with requirements and billing.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability 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:
Provider monitoring, Encounter forms, 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 = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
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**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state 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. The audits described in Appendix I-1 and the claims validation described in Appendix I-2-d help ensure payments are made only to qualified providers for services provided to waiver participants and authorized in the ISP.

Ongoing billing validation is done first through PROMISe, Pennsylvania's Medicaid Management Information System (MMIS). PROMISe verifies participant information in the Client Information System (CIS), such as the participants Master Client Index (MCI) number, name, the participants eligibility status, and effective eligibility dates. PROMISe also verifies that the provider(s) and service(s) on the claim are enrolled providers of the services and the services are in the Adult Autism Waiver.

After validation of the above listed items occurs, the claim information is sent to HCSIS to be verified against the participants ISP. If any of the information on the PROMISe claim is in conflict with the ISP, HCSIS sends an error code to PROMISe. PROMISe then suspends or rejects the claim. This system edit provides an upfront monitoring of eligibility status and authorized services as per the approved ISP. PROMISe then 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(s) and resubmit them.

BAS further assures the state’s accountability by reviewing all claims rejected by PROMISe on a quarterly basis. BAS monitors providers claims rejection status and provides necessary training and direction to limit such errors/rejections.

To ensure services were provided as billed, during the annual monitoring cycle, BAS will review a representative sample of all claims billed and compare them to the provider’s documentation which includes service notes, encounter forms and time sheets. During the monitoring, Program Monitors review provider claims for each

participant in the monitoring sample for a period of three to six months. For the Supports Coordination service, BAS reviews a sample of service notes in HCSIS to assess whether billing reflects the amount of Supports Coordination activity recorded in the notes. If an irregularity is discovered, BAS will work with the provider to determine whether remediation is required.

If a concerning issue is found, BAS will address the issue directly with the provider to come to a resolution or to offer training as needed. In addition, this review allows BAS to discover any potential systemic issues that may need to be addressed. Finally, BAS will monitor annually to ensure that the proper rates for BAS services are loaded into PROMISe for each service and unit of service.

BAS also interviews participants during annual monitoring to assess whether participants reporting of service delivery is consistent with claims data.
Findings from the annual monitoring activities are aggregated to enable data analysis, e.g., compliance by region, by provider, or by service to identify trends in compliance.

Another financial accountability check occurs at the time of review of each participant's annual level-of-care (LOC) documentation. If that documentation has lapsed, BAS instructs the participant's providers to suspend service delivery until the LOC documentation has been submitted. Once the documentation is reviewed and accepted, services are resumed for the participant.
No capitation payments are paid under this waiver.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
On an ongoing basis, if a Supports Coordinator suspects that a provider is billing inappropriately, the Supports Coordinator will inform BAS staff by phone or e-mail of the situation. BAS staff may also suspect inappropriate billing and pursue that concern at the Regional Office level.

For example, BAS may initiate an internal review of the provider's billing history through HCSIS reports and may expand that investigation. An expanded investigation could include onsite review of services rendered reports, time sheets, and claims to determine if inaccurate or inappropriate billings were submitted. If the suspicion is substantiated, BAS staff will require the provider agency to do an analysis of individual staff time sheets and/or other documentation and may request that the provider submit a summary report of findings and resolution to the BAS.

During the annual monitoring activities described above, when a provider's claim(s) cannot be validated by the Program Monitor, the provider is instructed to remediate the finding appropriately, e.g., paid funds will be recouped. If a pattern of inaccurate provider billing is discovered during annual monitoring, this would be documented on the provider's monitoring findings and BAS requests a Plan of Correction to be developed. As deemed appropriate, a meeting would be held with BAS and the provider agency to correct the issue moving forward. In some cases, the provider could face sanctions or be terminated as an AAW service provider.

Depending upon the findings of ad hoc and/or annual monitoring reviews, the following remediation strategies could be approved and carried out:
o A time-limited monitoring by a provider supervisor of weekly time sheets submitted by the provider's staff;
o Suspension of enrollment of new services or service locations for the provider;
o Sanctions or termination of the provider's contract(s);
o Recouping fund paid to the provider inappropriately;
o Training of provider staff in documentation of services rendered and ongoing monitoring of that documentation;

In any of the above situations, if the findings result in suspected fraud or abuse, BAS will report the provider staff or individual staff person to the DHS, Office of Administration for appropriate investigation and legal action as necessary.

Regarding assuring that rates are consistent with the approved methodology, the reimbursement logic built into PROMISe ensures that providers are not paid more than the rate that is stored in the system; that waiver participants are eligible for services on the date the service was provided; and that services paid are authorized in the waiver participant's approved ISP. If there is a problem, it can be identified by the provider(s), contractors,

BAS staff, or OMAP.

The ODP Claims Resolution Section has the ability to conduct research to identify if the reimbursement or eligibility information was incorrect or whether services paid are inconsistent with the services authorized in the ISP. If a problem is validated, appropriate corrective action is identified promptly.

Systemic errors are corrected in collaboration with the MMIS contractor and, if necessary, with the contractor who supports HCSIS. Rates or eligibility information entered into the system incorrectly would be corrected and the universe of paid claims that was processed using the incorrect information would be identified and adjusted.

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**
	☐ **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).

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, and Transitional Work Services. The rates for this

program are published for all providers. The fee schedule has no regional variation. There is no cost settlement. The state does not use other funding sources to compute budget neutrality.

BAS pays for waiver services based on a fee schedule, and the fees are developed using a market-based approach. Assumptions for supervisory staff, occupancy costs, indirect costs and administration costs are developed based on program requirements and each represent different costs that a provider would incur in delivering the service. The assumptions for these items do not include duplicative activities or costs.

For Assistive Technology, Community Transition Services, Home Modifications, and Vehicle Modifications providers are reimbursed at the invoice cost for the service or equipment provided. Total costs may not exceed limits in Appendix C-3 for each service. PROMISe™ checks claims against any applicable limitations to ensure the total costs do not exceed the service limits in Appendix C-3. When a participant is assessed, either initially or annually, their need for assistive technology, community transition services, and home or vehicle modifications is made. The approved assistive technology, community transition services, and home and vehicle modifications are placed on the participant's service plan. The participant's Supports Coordinator locates the services from qualified providers and equipment from qualified vendors and arranges for the participant to receive training to be able to use it (for equipment) and receives feedback from the family or representative (for the community transition services and home or vehicle modifications).

BAS contracted with Mercer Government Human Services Consulting (Mercer) from May to August 2015 to review the fee schedule rates for all existing and proposed services and service components for those services that are paid based on a statewide fee schedule. In developing payment rates for these services, Mercer's methodology contained an analysis of four key components: direct care salary expenses, employee related expenses, program expenses and administrative expenses. Mercer conducted a compensation study to determine the appropriate wage or salary expense for the direct care workers providing each service. Mercer reviewed 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.

In developing the other three rate components, Mercer and BAS first discussed the allowable costs to be funded through each service and included only allowable program and administrative expenses.

Mercer used this information to develop rates that comply with the requirements of Section 1902(a)30(A) of the Social Security Act (i.e., payments are consistent with economy, efficiency and quality of care and are sufficient to enlist enough providers) and the related federal regulations at 42 CFR 447.200 205. BAS reviews provider enrollment and retention for each service annually to ensure that access to care and adequacy of payments are maintained.

There are only two reasons rates may vary for different providers of the same service:
1. For services where there are different rates by level such as Residential Habilitation, Day Habilitation, and Transitional Work, all providers who deliver a service at the same level are paid the same rate.
2. Rates for Assistive Technology, Community Transition Services, Home Modifications, and Vehicle Modifications vary based on the invoice cost of the particular items.

In accordance with 42 CFR 441.310(a)(2), FFP is not claimed for room and board costs except as part of respite services when provided in a licensed or certified respite facility and not a private residence. Room and board costs are not included in the rates for any of the other services.

BAS made the rates available to waiver participants, providers and the public through the DHS Web site and publication in The Pennsylvania Bulletin. If a change in the methodology occurs, BAS will amend the waiver and provide CMS with the updated methodology, as well as publish the change in The Pennsylvania Bulletin.

The OMAP reimburses qualified providers through the Medicaid Management Information System, called the Provider Reimbursement and Operations Management Information System (PROMISe). Payments are made directly to the provider of record.

BAS reviews provider enrollment and retention for each service annually to ensure that access to care and adequacy of payments are maintained. The BAS has staff that continuously focuses on recruiting and enrolling providers based on provider interest and areas of greatest need geographically to ensure participant choice. As the program grows, the BAS expects to increase the pool of providers to provide meaningful choice among providers to meet the needs of multiple participants in each county. The BAS reviews the AAW Provider Enrollment database on an annual basis, to ensure that all providers' qualifications have been verified as specified in the approved waiver.

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. BAS reviews a customized summary report from Promise showing rejected claims on a quarterly basis.

BAS 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, BAS compares paid claims data to provider records such as time sheets and reports of services rendered. BAS 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. BAS 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:

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 mental retardation diagnosis.

A County MH/IID agency can enroll for any service for which the organization meets the qualifications in Appendix C-3. Services listed in the waiver are Assistive Technology, Specialized Skill Development, Career Planning, 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 Transitional Work Services.

The process for counties is the same as for all other providers. During the provider application process, the BAS staff determines whether the provider meets the provider qualification criteria outlined in this waiver. If the provider meets the criteria, the BAS notifies the Office of Medical Assistance Programs (OMAP), that the provider has been determined qualified by BAS. OMAP then authorizes that provider to be added to ISPs of AAW participants and to bill against the AAW.

The BAS reviews provider qualifications at least biennially. If findings from discovery activities indicate a provider does not meet provider standards, the BAS will contact the provider for more information to assess whether the provider meets standards. If a provider does not meet provider standards, the BAS will give the provider 30 days to remediate the reason for ineligibility. The BAS 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 BAS 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 BAS 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.

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 Transitional Work Services.

The process for counties is the same as for all other providers. During the provider application process, the BAS staff determines whether the provider meets the provider qualification criteria outlined in this waiver. If the provider meets the criteria, the BAS notifies the Office of Medical Assistance Programs (OMAP), that the provider has been determined qualified by BAS. OMAP then authorizes that provider to be added to ISPs of AAW participants and to bill against the AAW.

The BAS reviews provider qualifications at least biennially. If findings from discovery activities indicate a provider does not meet provider standards, the BAS will contact the provider for more information to assess whether the provider meets standards. If a provider does not meet provider standards, the BAS will give the provider 30 days to remediate the reason for ineligibility. The BAS 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 BAS 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 BAS 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 agencies can apply to become OHCDS entities for the Adult Autism Waiver services of Community Transition Services, Assistive Technology, Home Modifications and/or Vehicle Modifications. Supports Coordination agencies 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, and/or Vehicle Modifications. Specialized Skill Development agencies qualify for OHCDS designation because they provide Specialized Skill Development as a direct service.

To assure that OHCDS subcontractors possess the required qualifications, when monitoring OHCDS, BAS reviews documentation that subcontractors possess the required qualifications.

When monitoring OHCDS, BAS will review documentation of the contracting mechanism between the OHCDS and the provider. OHCDS is only allowed in this waiver for services for which providers are paid based on invoice costs—Home Modifications, Assistive Technology, Community Transition Services, 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.

(b) Home Modifications, Community Transition Services, Assistive Technology, 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 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, 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.

When a Supports Coordination agency acts as an OHCDS, there is no incentive for the agency to refer a person to itself as an OHCDS. In the AAW, an OHCDS may not bill an administrative fee for acting as an OHCDS. The state pays the same amount—the provider's invoice cost—whether the person's chosen provider is directly enrolled or working through an OHCDS.

(d) Agencies or individuals who provide Community Transition Services, Assistive Technology, Home and Vehicle Modifications must meet all Adult Autism Waiver requirements. The Supports Coordinator must document the successful delivery or completion of the services once completed.

(e) & (f) BAS reviews all ISPs and scrutinizes Community Transition Services, Assistive Technology, Home Modifications 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 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, BAS reviews the Supports Coordination agency 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. BAS will also ensure the arrangements between the OHCDS entity and the agency or individual providing the service meet OHCDS requirements. These arrangements may not be formal contracts as these services generally represent short-term or single purchase transactions.

The OHCDS does not perform administrative activities.

The OHCDS-designated provider is the "provider of record" of the service. BAS 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, BAS 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 BAS.

There is no additional cost to the state if a directly enrolled provider also provides services under contract with an OHCDS. The state pays the same amount—the provider's invoice cost—whether the person's chosen provider is directly enrolled or working through an OHCDS.

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, 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, a Medical Assistance supplemental agreement specific to the AAW is executed.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

○ **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.**

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	51824.52	8329.65	60154.17	217159.00	5442.00	222601.00	162446.83
3	51824.52	8329.65	60154.17	217159.00	5442.00	222601.00	162446.83
4	51824.52	8329.65	60154.17	217159.00	5442.00	222601.00	162446.83
5	51824.52	8329.65	60154.17	217159.00	5442.00	222601.00	162446.83

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	702	702
Year 4	702	702
Year 5	702	702

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.

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 year 1.

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 year 1, 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 year 1:
Of the 668 people enrolled in year 1, 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 = 213,725

Average length of stay for waiver year 1 is calculated as total days of service divided by the unduplicated number of participants: 213,725/702 = 305.

There is no change in waiver capacity during years 2-5.

Average length of stay for years 2-5 is calculated as 634 people served for the entire year (668-34 people disenrolled). Total is 231,410 days (634 people times 365 days). 34 people are assumed to disenroll each year and 120 days will be necessary to enroll new people into the waiver. Capacity for the 34 people will be used for an average of 245 days (365-120). Total is 8,330 days (34 people times 245 days.)

Total days of service for years 2-5: 8,330 + 231,410 = 239,740

Average length of stay is calculated as total days of service divided by the unduplicated number of participants for years 2-5: 239,740/702 = 342 days

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

For Factor D the assumptions made for average length of stay apply per Appendix J-2-b. Participant capacity is assumed to be held constant and fee schedule rates are assumed to be held constant as well as length of stay, intake and service utilization methodology over the five years.

Data for paid claims for SFY 2014/15, SFY 2015/16 and the first 2 quarters of SFY 2016/17, extracted from the DHS data warehouse, were used as the basis for Factor D for most services.

Data for SFY 2014/15 and SFY 2015/16 were analyzed to identify utilization trends for each service. Data from the first 2 quarters of the SFY 2016/17 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, SFY 2015/16 and the first 2 quarters of SFY 2016/17. 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:

- In the most recent waiver renewal, new services in part replaced or expanded previous AAW services. Projections were based on utilization paid claims data for those services in the first 2 quarters of SFY 2016/17. New services added in the renewal include Family Support, Systematic Skill Building, Home Modifications, and Vehicle Modifications.

For services that had no paid claims in SFY 2015/16. 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:

BAS based the Factor D' estimate on actual claims and encounter data for individuals served in Pennsylvania's Adult Autism Waiver in State Fiscal Year (SFY) 2014/2015. For each year, Factor D' was multiplied by the ratio of the projected average length of stay for that year to the SFY 2014/15 average length of stay. The entire time period used for estimates occurred after Medicare PART D was implemented, so Part D costs are removed.

Factor D’ at J-1, column 3 is $8,329.65, the Factor D’ value reported in the most recent 372 Report for SFY 2014/15. That level is held constant for WY 1-5.

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:

BAS based the Factor G estimate on actual claims data paid through 06/30/2016 with a projection factor for individuals served in Pennsylvania's ICF/IID and ICF/ORC in State Fiscal Year (SFY) 2014/15. BAS did not adjust the estimate for length of stay. The average length of stay in the ICF/IID and ICF/ORC claims data is similar to the average length of stay assumed for all years of the waiver.

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:

BAS based the Factor G' estimate on actual claims data paid through 6/30/2016 with a projection factor for individuals served in Pennsylvania's ICF/IID and ICF/ORC in State Fiscal Year (SFY) 2014/15. BAS did not adjust the estimate for length of stay. The average length of stay in the ICF/IID claims data is similar to the average length of stay assumed for all years of the waiver.

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	
Specialized Skill Development	
Temporary Supplemental Services	
Transitional Work Services	
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**
			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
Out of Home- Daily	Day	22	22.00	191.61	**92739.24**	
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**	
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	1	1.00	3815.00	**3815.00**	
Nutritional Consultation Total:						**29906.25**
Nutritional Consultation	15 min.	25	75.00	15.95	**29906.25**	

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
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**	
Transitional Work Services Total:						**18886.86**
Transitional Work Services	15 min.	1	5958.00	3.17	**18886.86**	
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:						**189902.57**
Day Habilitation	15 min.	11	3239.00	5.33	**189902.57**	
Residential Habilitation Total:						**4486824.32**
Community Home	Day	44	319.00	296.44	**4160831.84**	
Family Living Home	Day	8	319.00	127.74	**325992.48**	
Respite Total:						**326849.25**
Out of Home- Daily	Day	25	30.00	191.61	**143707.50**	
Out of Home-15 min	15 min.	15	115.00	4.79	**8262.75**	
In-home-15 min	15 min.	45	635.00	6.12	**174879.00**	
Supported Employment Total:						**1333009.20**
Intensive Job Coaching	15 min.	134	871.00	10.95	**1278018.30**	
Extended Employment Supports	15 min.	62	81.00	10.95	**54990.90**	
Supports Coordination Total:						**2465745.26**
Supports Coordination	15 min	702	203.00	17.05	**2429727.30**	
Supports Coordination Initial Plan Development	Plan	44	1.00	818.59	**36017.96**	
Therapies Total:						**132608.31**
Therapies - Counseling	15 min.	49	127.00	21.29	**132487.67**	
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:						**111903.75**
Vocational Assessment	15 min.	25	55.00	13.05	**17943.75**	
Job Finding	15 min.	45	160.00	13.05	**93960.00**	
Community Transition Services Total:						**9157.14**
Community Transition Services	Item	2	1.00	4578.57	**9157.14**	

GRAND TOTAL:	**36380809.89**
Total Estimated Unduplicated Participants:	**702**
Factor D (Divide total by number of participants):	**51824.52**
Average Length of Stay on the Waiver:	342

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Support Total:						**13194.72**
Family Support	15 min.	21	33.00	19.04	**13194.72**	
Home Modifications Total:						**3815.00**
Home Modifications	Item	1	1.00	3815.00	**3815.00**	
Nutritional Consultation Total:						**43065.00**
Nutritional Consultation	15 min.	30	90.00	15.95	**43065.00**	
Specialized Skill Development Total:						**27241740.51**
Behavior Specialist Services-Ongoing Consultative	15 min.	450	300.00	18.37	**2479950.00**	
Behavior Specialist Services-Ongoing Direct	15 min.	450	635.00	18.37	**5249227.50**	
FBA and BSP/CIP Development	Plan	81	1.00	1469.93	**119064.33**	
Systematic Skill Building - Ongoing Direct	15 min.	135	300.00	15.37	**622485.00**	
Systematic Skill Building - Ongoing Consultative	15 min.	135	120.00	15.37	**248994.00**	
Systematic Skill Building - Skill Building Plan Development	unit	98	1.00	491.76	**48192.48**	
Community Support 1:1	15 min.	621	3302.00	9.00	**18454878.00**	
Community Support 1:2	15 min.	30	121.00	5.00	**18150.00**	
Community Support 1:3	15 min.	10	24.00	3.33	**799.20**	
Temporary Supplemental Services Total:						**900.00**
Temporary Supplemental Services	15 min	2	50.00	9.00	**900.00**	
Transitional Work Services Total:						**18886.86**
Transitional Work Services	15 min.	1	5958.00	3.17	**18886.86**	
Vehicle Modifications Total:						**1908.00**
Vehicle Modifications	unit	1	1.00	1908.00	**1908.00**	
				GRAND TOTAL:		**36380809.89**
				Total Estimated Unduplicated Participants:		**702**
				Factor D (Divide total by number of participants):		**51824.52**
				Average Length of Stay on the Waiver:		342

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:						**189902.57**
Day Habilitation	15 min.	11	3239.00	5.33	**189902.57**	
Residential Habilitation Total:						**4486824.32**
Community Home	Day	44	319.00	296.44	**4160831.84**	
Family Living Home	Day	8	319.00	127.74	**325992.48**	
Respite Total:						**326849.25**
Out of Home- Daily	Day	25	30.00	191.61	**143707.50**	
Out of Home-15 min	15 min.	15	115.00	4.79	**8262.75**	
In-home-15 min	15 min.	45	635.00	6.12	**174879.00**	
Supported Employment Total:						**1333009.20**
Intensive Job Coaching	15 min.	134	871.00	10.95	**1278018.30**	
Extended Employment Supports	15 min.	62	81.00	10.95	**54990.90**	
Supports Coordination Total:						**2465745.26**
Supports Coordination	15 min	702	203.00	17.05	**2429727.30**	
Supports Coordination Initial Plan Development	Plan	44	1.00	818.59	**36017.96**	
Therapies Total:						**132608.31**
Therapies - Counseling	15 min.	49	127.00	21.29	**132487.67**	
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:						**111903.75**
Vocational Assessment	15 min.	25	55.00	13.05	**17943.75**	

GRAND TOTAL:	**36380809.89**
Total Estimated Unduplicated Participants:	**702**
Factor D (Divide total by number of participants):	**51824.52**
Average Length of Stay on the Waiver:	342

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Job Finding	15 min.	45	160.00	13.05	**93960.00**	
Community Transition Services Total:						**9157.14**
Community Transition Services	Item	2	1.00	4578.57	**9157.14**	
Family Support Total:						**13194.72**
Family Support	15 min.	21	33.00	19.04	**13194.72**	
Home Modifications Total:						**3815.00**
Home Modifications	Item	1	1.00	3815.00	**3815.00**	
Nutritional Consultation Total:						**43065.00**
Nutritional Consultation	15 min.	30	90.00	15.95	**43065.00**	
Specialized Skill Development Total:						**27241740.51**
Behavior Specialist Services-Ongoing Consultative	15 min.	450	300.00	18.37	**2479950.00**	
Behavior Specialist Services-Ongoing Direct	15 min.	450	635.00	18.37	**5249227.50**	
FBA and BSP/CIP Development	Plan	81	1.00	1469.93	**119064.33**	
Systematic Skill Building - Ongoing Direct	15 min.	135	300.00	15.37	**622485.00**	
Systematic Skill Building - Ongoing Consultative	15 min.	135	120.00	15.37	**248994.00**	
Systematic Skill Building - Skill Building Plan Development	unit	98	1.00	491.76	**48192.48**	
Community Support 1:1	15 min.	621	3302.00	9.00	**18454878.00**	
Community Support 1:2	15 min.	30	121.00	5.00	**18150.00**	
Community Support 1:3	15 min.	10	24.00	3.33	**799.20**	
Temporary Supplemental Services Total:						**900.00**
Temporary Supplemental Services	15 min	2	50.00	9.00	**900.00**	
Transitional Work Services Total:						**18886.86**
Transitional Work Services	15 min.	1	5958.00	3.17	**18886.86**	
Vehicle Modifications Total:						**1908.00**
Vehicle Modifications	unit	1	1.00	1908.00	**1908.00**	
				GRAND TOTAL:		**36380809.89**
				Total Estimated Unduplicated Participants:		**702**
				Factor D (Divide total by number of participants):		**51824.52**
				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:						**189902.57**
Day Habilitation	15 min.	11	3239.00	5.33	**189902.57**	
Residential Habilitation Total:						**4486824.32**
Community Home	Day	44	319.00	296.44	**4160831.84**	
Family Living Home	Day	8	319.00	127.74	**325992.48**	
Respite Total:						**326849.25**
Out of Home- Daily	Day	25	30.00	191.61	**143707.50**	
Out of Home-15 min	15 min.	15	115.00	4.79	**8262.75**	
In-home-15 min	15 min.	45	635.00	6.12	**174879.00**	
Supported Employment Total:						**1333009.20**
Intensive Job Coaching	15 min.	134	871.00	10.95	**1278018.30**	
Extended Employment Supports	15 min.	62	81.00	10.95	**54990.90**	
Supports Coordination Total:						**2465745.26**
Supports Coordination	15 min	702	203.00	17.05	**2429727.30**	
Supports Coordination Initial Plan Development	Plan	44	1.00	818.59	**36017.96**	
Therapies Total:						**132608.31**
Therapies - Counseling	15 min.	49	127.00	21.29	**132487.67**	
Therapies - Speech	15 min.	1	8.00	15.08	**120.64**	
Assistive Technology Total:						**1300.00**
Assistive Technology					**1300.00**	
			GRAND TOTAL:			**36380809.89**
			Total Estimated Unduplicated Participants:			**702**
			Factor D (Divide total by number of participants):			**51824.52**
			Average Length of Stay on the Waiver:			342

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Item	2	1.00	650.00		
Career Planning Total:						**111903.75**
Vocational Assessment	15 min.	25	55.00	13.05	**17943.75**	
Job Finding	15 min.	45	160.00	13.05	**93960.00**	
Community Transition Services Total:						**9157.14**
Community Transition Services	Item	2	1.00	4578.57	**9157.14**	
Family Support Total:						**13194.72**
Family Support	15 min.	21	33.00	19.04	**13194.72**	
Home Modifications Total:						**3815.00**
Home Modifications	Item	1	1.00	3815.00	**3815.00**	
Nutritional Consultation Total:						**43065.00**
Nutritional Consultation	15 min.	30	90.00	15.95	**43065.00**	
Specialized Skill Development Total:						**27241740.51**
Behavior Specialist Services-Ongoing Consultative	15 min.	450	300.00	18.37	**2479950.00**	
Behavior Specialist Services-Ongoing Direct	15 min.	450	635.00	18.37	**5249227.50**	
FBA and BSP/CIP Development	Plan	81	1.00	1469.93	**119064.33**	
Systematic Skill Building - Ongoing Direct	15 min.	135	300.00	15.37	**622485.00**	
Systematic Skill Building - Ongoing Consultative	15 min.	135	120.00	15.37	**248994.00**	
Systematic Skill Building - Skill Building Plan Development	unit	98	1.00	491.76	**48192.48**	
Community Support 1:1	15 min.	621	3302.00	9.00	**18454878.00**	
Community Support 1:2	15 min.	30	121.00	5.00	**18150.00**	
Community Support 1:3	15 min.	10	24.00	3.33	**799.20**	
Temporary Supplemental Services Total:						**900.00**
Temporary Supplemental Services	15 min	2	50.00	9.00	**900.00**	
Transitional Work Services Total:						**18886.86**

GRAND TOTAL:	**36380809.89**
Total Estimated Unduplicated Participants:	**702**
Factor D (Divide total by number of participants):	**51824.52**
Average Length of Stay on the Waiver:	342

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transitional Work Services	15 min.	1	5958.00	3.17	**18886.86**	
Vehicle Modifications Total:						**1908.00**
Vehicle Modifications	unit	1	1.00	1908.00	**1908.00**	
				GRAND TOTAL:		**36380809.89**
				Total Estimated Unduplicated Participants:		**702**
				Factor D (Divide total by number of participants):		**51824.52**
				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:						**189902.57**
Day Habilitation	15 min.	11	3239.00	5.33	**189902.57**	
Residential Habilitation Total:						**4486824.32**
Community Home	Day	44	319.00	296.44	**4160831.84**	
Family Living Home	Day	8	319.00	127.74	**325992.48**	
Respite Total:						**326849.25**
Out of Home- Daily	Day	25	30.00	191.61	**143707.50**	
Out of Home-15 min	15 min.	15	115.00	4.79	**8262.75**	
In-home-15 min	15 min.	45	635.00	6.12	**174879.00**	
Supported Employment Total:						**1333009.20**
Intensive Job Coaching	15 min.	134	871.00	10.95	**1278018.30**	
Extended Employment Supports	15 min.	62	81.00	10.95	**54990.90**	
Supports Coordination Total:						**2465745.26**
Supports Coordination					**2429727.30**	
				GRAND TOTAL:		**36380809.89**
				Total Estimated Unduplicated Participants:		**702**
				Factor D (Divide total by number of participants):		**51824.52**
				Average Length of Stay on the Waiver:		342

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 min	702	203.00	17.05		
Supports Coordination Initial Plan Development	Plan	44	1.00	818.59	**36017.96**	
Therapies Total:						**132608.31**
Therapies - Counseling	15 min.	49	127.00	21.29	**132487.67**	
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:						**111903.75**
Vocational Assessment	15 min.	25	55.00	13.05	**17943.75**	
Job Finding	15 min.	45	160.00	13.05	**93960.00**	
Community Transition Services Total:						**9157.14**
Community Transition Services	Item	2	1.00	4578.57	**9157.14**	
Family Support Total:						**13194.72**
Family Support	15 min.	21	33.00	19.04	**13194.72**	
Home Modifications Total:						**3815.00**
Home Modifications	Item	1	1.00	3815.00	**3815.00**	
Nutritional Consultation Total:						**43065.00**
Nutritional Consultation	15 min.	30	90.00	15.95	**43065.00**	
Specialized Skill Development Total:						**27241740.51**
Behavior Specialist Services-Ongoing Consultative	15 min.	450	300.00	18.37	**2479950.00**	
Behavior Specialist Services-Ongoing Direct	15 min.	450	635.00	18.37	**5249227.50**	
FBA and BSP/CIP Development	Plan	81	1.00	1469.93	**119064.33**	
Systematic Skill Building - Ongoing Direct	15 min.	135	300.00	15.37	**622485.00**	
Systematic Skill Building - Ongoing Consultative	15 min.	135	120.00	15.37	**248994.00**	
Systematic Skill Building - Skill Building Plan Development	unit	98	1.00	491.76	**48192.48**	
			GRAND TOTAL:			**36380809.89**
			Total Estimated Unduplicated Participants:			**702**
			Factor D (Divide total by number of participants):			**51824.52**
			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.	621	3302.00	9.00	**18454878.00**	
Community Support 1:2	15 min.	30	121.00	5.00	**18150.00**	
Community Support 1:3	15 min.	10	24.00	3.33	**799.20**	
Temporary Supplemental Services Total:						**900.00**
Temporary Supplemental Services	15 min	2	50.00	9.00	**900.00**	
Transitional Work Services Total:						**18886.86**
Transitional Work Services	15 min.	1	5958.00	3.17	**18886.86**	
Vehicle Modifications Total:						**1908.00**
Vehicle Modifications	unit	1	1.00	1908.00	**1908.00**	

GRAND TOTAL:	**36380809.89**
Total Estimated Unduplicated Participants:	**702**
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