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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

## 1. Request Information

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

**B. Program Title:**
**Person/Family Directed Support Waiver (P/FDS)**

**C. Waiver Number:PA.0354**
**Original Base Waiver Number: PA.0354.9**

**D. Amendment Number:**

**E. Proposed Effective Date:** (mm/dd/yy)
01/01/22
**Approved Effective Date of Waiver being Amended: 07/01/17**

## 2. Purpose(s) of Amendment

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

## 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** | |

| Component of the Approved Waiver | Subsection(s) |
|---|---|
| ☐ Appendix B Participant Access and Eligibility | |
| ☐ Appendix C Participant Services | |
| ☐ 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*):

Person/Family Directed Support Waiver (P/FDS)

**C. Type of Request: amendment**

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

○ **3 years** ◉ **5 years**

**Original Base Waiver Number: PA.0354**
**Draft ID: PA.002.04.06**

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

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended: 07/01/17**
**Approved Effective Date of Waiver being Amended: 07/01/17**

**PRA Disclosure Statement**

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

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

## 1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**
If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

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People of any age with a diagnosis of an intellectual disability or autism, children with a developmental disability under age 9 with a high probability of resulting in an intellectual disability or autism and children under age 22 with a developmental disability due to a medically complex condition as outlined in appendix B-6 of this waiver and by ODP policy regarding individual eligibility for Medicaid Waiver services.

## 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.

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The P/FDS Waiver has been developed to emphasize deinstitutionalization, prevent or minimize institutionalization and provide an array of services and supports in community-integrated settings. The P/FDS Waiver is designed to support persons of any age with an intellectual disability or autism, children with a developmental disability under age 9 with a high probability of resulting in an intellectual disability or autism and children under age 22 with a developmental disability due to a medically complex condition to live more independently in their homes and communities and to provide a variety of services that promote community living, including participant directed service models and traditional agency-based service models.

The Department of Human Services (Department), as the State Medicaid agency, retains authority over the administration and implementation of the P/FDS Waiver. ODP, as part of the State Medicaid Agency, is responsible for the development and distribution of policies, procedures, and rules related to Waiver operations. Most services and supports funded under the Waiver are authorized by local Administrative Entities (AEs) pursuant to an AE Operating Agreement with ODP. There are some service variances, such as Respite beyond the limitations,that require prior approval from ODP. An AE is a County Mental Health/Intellectual Disability (MH/ID) Program or a non-governmental entity with a signed agreement with ODP to perform operational and administrative functions delegated by ODP related to the approved P/FDS Waiver. The AE Operating Agreement establishes the roles and responsibilities of AEs with respect to functions delegated to them for program administration.

AEs may only delegate and purchase administrative functions in accordance with the AE Operating Agreement. When the AE delegates or purchases administrative functions, the AE shall continue to retain responsibility for compliance with the AE Operating Agreement. In addition, the AE is responsible to monitor delegated or purchased administrative functions to ensure compliance with applicable Departmental rules, Waiver requirements, written policies and procedures, state and federal laws, and the provisions of the AE Operating Agreement. Administrative payments for the purchased administrative functions shall be paid through the Department's allocation to the AE for administration of the Waiver.

AEs are responsible for ensuring that service plans are completed accurately before authorizing the services and approving the service plans. AEs utilize the results of needs assessments, the standardized web-based service plan format in the Home and Community Services Information System (HCSIS) and service plan guidelines to ensure accuracy of the service plans. AEs are also responsible for ensuring that service plans are approved and services are authorized prior to the participant's receipt of Waiver services; and that service plans include the services and supports necessary to meet the assessed needs of participants. AEs are responsible for monitoring that service plans are updated on at least an annual basis, and whenever necessary to reflect changes in the need of Waiver participants.

## 3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

## 4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

*geographic area:*

## 5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

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

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

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

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

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

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

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

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

**Appendix H**.

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

Through a notice published on June 8, 2019, DHS informed interested persons of the availability of the proposed amendment for public comment. This notice can be accessed online at https://www.pabulletin.com/secure/data/vol49/49-23/867.html and via subscription. The public comment period was open until 11:59pm on July 8, 2019. Written comments were accepted via electronic mail and postal mail. Verbal comments were accepted through 2 teleconferences held on June 20 and June 24. ODP staff also participated in 1 teleconference with self-advocates.

The Pennsylvania Bulletin is published weekly under 4 Pa.C.S. Part II (relating to publication and effectiveness of Commonwealth documents). ODP sent notification of the publication via our ListServ that includes providers, Supports Coordination Organizations, advocacy organizations, individuals and families. The notice also indicates that copies of the notice and proposed amendment could be obtained at one of the four regional ODP offices.

Tribal Government notice was not required as there are no federally-recognized Tribal Governments that maintain a primary office and/or majority population in Pennsylvania.

ODP received written comments from 17 individuals and organizations regarding the proposed amendments. Approximately 319 telephone lines (this could represent one individual or a group of individuals) were utilized during the 2 teleconferences in June. The following is a general summary of comments received on the proposed amendments.

•8 comments were received regarding the responsibility of Administrative Entities (AEs) to plan for the enrollment of individuals who will graduate from special education each year and who are not eligible to continue their education through the next year. Two comments requested that individuals be enrolled prior to graduation to promote planning and competitive integrated employment. Seven comments recommended that Administrative Entities plan for individuals who graduate at 18.
ODP Response: No changes were made to this requirement. Individuals with an intellectual disability or autism diagnosis are eligible to receive transition services through their public-school system until age 21. The Individuals with Disabilities Education Act (IDEA) and Pennsylvania's Special Education Law recognize the importance of preparing youth for success after high school. These laws state that transition planning for students who receive special education services and have an Individualized Education Program (IEP) must begin in the school year the student turns 14. Transition planning means evaluating needs, strengths, and skills required for a student to move from high school to postsecondary life. The IEP must include appropriate measurable postsecondary goals based upon age appropriate transition assessments related to training, education, employment, and, where appropriate, independent living skills and the transition services (including courses of study) needed to assist the child in reaching those goals. Transition services can occur in settings outside of the school/classroom.

Further, individuals of any age may be enrolled in the waiver when the AE has waiver capacity available and the individual has an emergency need as identified in the Prioritization of Urgency of Need for Services (PUNS).

The general summary of comments received on the proposed amendments is continued in main module-additional needed information.

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

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

## 7. Contact Person(s)

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

**Last Name:** Allen

**First Name:** Leesa

**Title:** Deputy Secretary

**Agency:** Office of the Secretary

**Address:** 625 Forster Street, Health and Welfare Building

**Address 2:**

**City:** Harrisburg

**State:** **Pennsylvania**

**Zip:** 17120

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

**Fax:** (717) 787-6583

**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:** Director, Division of Policy

**Agency:** Office of Developmental Programs

**Address:** 625 Forster Street, Health and Welfare Building

**Address 2:**

**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:**

State Medicaid Director or Designee

**Submission Date:**

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Pennsylvania**

**Zip:**

**Phone:** **Ext:** ☐ **TTY**

**Fax:**

**E-mail:**

## Attachments

**Attachment #1: Transition Plan**

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

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

Specify the transition plan for the waiver:

This amendment clarifies that caregivers with whom the participant lives may not provide Companion services when the participant has been sleeping 5 or more hours and does not require direct care or supervision during those asleep hours. When direct care or supervision is provided, the caregiver may be reimbursed. An effective date of January 1, 2020 was added to ensure that service plan teams have time to implement this change.

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

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

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

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

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

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

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

Remediation Strategies - ODP'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. ODP may also prescribe certain requirements to become compliant. ODP 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.

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Home and Community-Based Settings
The Supports Coordination service definition states that Supports Coordinators are responsible for using a person centered planning approach and a team process to develop the participant's service plan to meet the participant's needs in the least restrictive manner possible. 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 any service in any private home purchased for, developed for or promoted as serving people with an intellectual disability and/or Autism 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 - 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.

Non-residential settings outside of the home include Community Participation, Respite, Therapies, Education Support, Music and Art Therapy and Equine Assisted Therapy. All of these service definitions have been revised or newly written to comply with the HCB Settings requirements. The service definition for Community Participation contains standards for setting size, location, and the percentage of time that participants are allowed to spend in the setting versus in the community.

ODP will permit respite to be provided in institutional settings for a duration that does not exceed 30 days. As per CMS guidance related to states use of institutional settings for the provision of respite services that typically do not exceed 30 days in duration, ODP will not assess settings exclusively used for respite services for compliance with home and community based settings requirement.

The service definition for Education Support contains a standard for the percentage of time that participants spend on campus that must be integrated with the general student population.

Music, Art Therapy and Equine Assisted Therapy have service limits incorporated to encourage further community integration.

ODP shall require, prior to enrollment of new providers, that the provider is assessed to confirm that settings will fully comport with all federal and state regulations as well as waiver requirements.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continuation of summary of comments

•Three comments were received recommending changes in how waiver capacity is allocated to AEs.
ODP Response: No change was made to this requirement. ODP will continue to analyze how waiver capacity is allocated to AEs and make changes if needed.

•Four comments were received expressing support for expanding the scope of professionals who can diagnose intellectual disability.
ODP Response: The waiver was submitted with the proposed change intact.

•Seven comments were received regarding the proposed addition of the on-call and remote support component in the Community Participation Support service. All of the comments supported this addition and requested more guidance on processes and procedures for implementation. One comment requested a specific language change regarding how providers inform participants about the impact of on-call and remote support.
ODP Response: ODP will provide further guidance about processes and procedures when the addition of on-call and remote support to the Community Participation Support service is approved by CMS. The requested language change was made.

•Four comments were received regarding changes in staffing ratios in the Community Participation Support service. The comments recommended that transportation of up to 6 participants be considered community and that ODP have ongoing dialogue with providers regarding implementation.
ODP Response: ODP is in the process of developing a Community Participation Support implementation group to explore ways to help participants develop and sustain a range of valued social roles and relationships, build natural supports, increase independence, increase potential for employment and experience meaningful community participation and inclusion.

•Five comments were received regarding the locations where Community Participation Support services can be rendered. Three comments requested additional clarification to ensure that implementation is consistent statewide. One comment was opposed to allowing the continued development of licensed facilities and using a tiered approach to allow current providers to serve a large number of individuals in licensed facilities that may be in close proximity to other service settings.
ODP Response: Locations where Community Participation Support can be provided will align with the 55 Pa. Code Chapter 6100 regulations which were developed through an extensive stakeholder engagement process and were unanimously approved by the Independent Regulatory Review Commission. Clarification on locations where Community Participation Support can be provided will be communicated through various documents such as the 55 Pa. Code Chapter 6100 Regulatory Compliance Guide and Community Participation Support question and answer document.

•Six comments were received supporting the addition that participants be offered opportunities and support to participate in community activities that are consistent with the individual's preferences, choices and interests.
ODP Response: The waiver was submitted with the proposed change intact.

•Four comments were received regarding delays in the provider qualification requirements for the prevocational component of Community Participation Support, Supported Employment and Small Group Employment. Three comments recommended that the effective date be 24 months following approval of the waiver amendment and give professionals 24 months after hire to obtain the required certificate. One comment requested that the requirement not apply to participant directed services.
ODP Response: No changes were made to the waiver based on these comments. The requirement for staff to obtain the Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE) or the Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training has been in the waivers since July 1, 2017. In ODP communication 102-18 published on November 26, 2018, ODP stated that this requirement was being delayed from January 1, 2019 to July 1, 2019 based on feedback that providers were struggling to have all required staff obtain the required certificate prior to the pending January 1, 2019 deadline. This communication stated, "It is imperative that all impacted providers and common law employers that have staff who are required to have one of these employment credentials or certificates start the process now if they have not already done so. There will be no further delays granted in implementation of this qualification criteria."

•Eight comments were received regarding referrals to the Office of Vocational Rehabilitation (OVR) during the closure of the order of selection. Four comments requested additional clarification as to how the closure of the order of selection impacts authorization of Supported Employment and Advanced Supported Employment services. Comments were generally supportive that Supported Employment and Advanced Supported Employment services could be provided without referring the individual to OVR during the closure of the order of selection.
ODP Response: ODP worked collaboratively with OVR to develop and publish bulletin 00-19-02 "OVR Referrals During a

Period when OVR's Order of Selection is Closed". This bulletin provided the clarification requested by the commenters. ODP and OVR will also hold a training session for AEs and supports coordinators on July 25 and a session for families, individuals and other interested stakeholder on July 30.

•Three comments were received requesting clarification whether remote support is covered under Supported Employment and Advanced Supported Employment.
ODP Response: Remote support as contemplated in Community Participation Support is not currently covered under Supported Employment and Advanced Supported Employment. No change was made to the waiver based on these comments. ODP will explore the feasibility of this recommendation through the development of a technology task force.

•Three comments were received regarding the Supported Employment and Advanced Supported Employment service requirement that OVR services are considered to not be available to the participant if OVR has not made an eligibility determination within 120 days of the referral being sent. The comments recommend that this be changed to 105 days and add that OVR services be deemed not available if OVR services are not deemed authorized and eligible for payment within 30 days of the OVR eligibility determination.
ODP Response: No changes were made based on these comments. ODP and OVR have different standards for determining when a referral has been sent which means the difference between the 105 days stipulated by the Rehabilitation Services Administration and the 120 days stipulated in the waivers are more aligned than the actual quoted number of days make them appear. As stipulated in bulletin 00-19-01, if an individual has been determined eligible for OVR services, OVR will complete an Individualized Plan for Employment within 90 days of the date the individual was determined eligible for OVR services. There are many individual specific circumstances that can impact this requirement.

•Two comments were received regarding Small Group Employment. One comment requested clarification regarding when services can be billed. One comment requested that Small Group Employment be limited to no more than three years.
ODP Response: The Small Group Employment service definition was revised to provide clarity regarding when services can be billed. ODP proposed to limit Small Group Employment services to three years when the waiver was renewed in July 2017 and received 98 comments mostly opposing this limit. No limit has been added at this time. ODP will explore whether limits should be added in the future.

•Four comments were received about the Respite service being provided in emergency situations beyond the home's approved program capacity. Two comments supported this change. One comment suggested that "emergency" be defined. One comment suggested adding clarification about approved licensed capacity.
ODP Response: The term "Emergency" is defined in the full Respite service definition that was posted on the DHS website. ODP is also revising the language to add requested clarification that Respite services in an emergency situation, may exceed the approved program capacity but may not exceed licensing capacity.

•Three comments were received regarding the addition to the Supports Coordination service definition that clarifies that monitoring includes the review of information in the health risk screening tool or whether there have been any changes in orders, plans or medical interventions prescribed or recommended and whether those changes are being implemented. One comment supported this addition, one comment requested clarification as to how this will be documented and one comment requested that implementation by providers be allowed in a reasonable timeframe.
ODP Response: No changes were made based on these comments. In accordance with the Health Risk Screening Tool (HRST) protocol released with ODP communication 19-052, supports coordinators (SCs) are responsible for the following:

o The SC will ensure that the risks identified by the HRST are captured in the Individual Support Plan and that a plan to mitigate the risk is identified. This risk mitigation is expected to include communication of HRST results with Primary Care Physicians, other medical professionals and Managed Care Organizations as appropriate.
o SCs are trained primarily via live training on how to best use the HRST information. SCs can apply their knowledge of the HRST during regular visits to promote and coordinate the health and safety of individuals receiving residential services.
o SCs should review the HRST prior to and during visits with the individual. The information found in the HRST assists the SC to have more effective collaboration with the provider.
o Any deviation from the plan to mitigate the risk approved by the individual's team shall be noted in the individual monitoring conducted by the SC. Additionally, the SC must ensure that the responsible provider's Program Specialist for the individual is made aware of any deviations, in writing, within 7 work days. An email sent to the Program Specialist within the expected time line will suffice to meet this requirement. Any notifications made by phone must be followed up with an email summarizing the conversation within the 7-day time line.
o SCs shall request explanation for any deviation and shall take appropriate action to notify the individual's team members. The SC will follow through until resolution.

•Five comments were received about In-Home and Community Support, Companion, and Community Participation Support. One comment expressed concern about the 40-hour limit on agency-employed support services. Three comments did not support the change to the Companion service regarding caregivers not being able to implement this service during the time the participant is sleeping and solely needs supervision. One comment recommended adding clarification on when these services can be provided in a hospital setting.
ODP response: The Companion service definition was revised based on these comments to state, “Effective January 1, 2020, caregivers with whom the participant lives may not provide Companion services when the participant has been sleeping 5 or more hours and does not require direct care or supervision during those asleep hours. When direct care or supervision is provided, the caregiver will be reimbursed”. Not allowing services to be rendered while a participant is hospitalized is a federal regulatory requirement that CMS wrote into the Main Module of the waiver application. ODP will clarify in the Individual Support Plan Manual that “inpatient” means that the person has been admitted. ODP agrees that the Communication Specialist should not override an up-to-date communication assessment. The service definition is written broadly so that it includes a review of communication needs which includes assessments.

•Four comments were received regarding Communication Specialist services. Two comments recommended that this service be used to teach American Sign Language, one comment recommended that the Communication Specialist not be allowed to override recommendations in a communication assessment and one comment requested revisions to the frequency that the action plan is evaluated and modified.
ODP Response: Recommended changes to the frequency that the action plan is evaluated and modified were written into the submitted waiver. Teaching American Sign Language to the participant is covered under Education Support and In-Home and Community Support services.

•One comment was received on Shift Nursing and when the service can be utilized during the provision of other services.
ODP Response: The comment pointed out an error in the Shift Nursing service definition in the P/FDS and Community Living Waivers. The service definition now states that Shift Nursing may not be provided at the same time as: “Respite (15-minute or Day); Companion; In-Home and Community Supports; Community Participation Support; Therapies; Consultative Nutritional Services”. Community Participation Support has enhanced rates that cover services provided by a nurse which is why it may not be provided at the same time as Shift Nursing.

•Four comments were received on Transportation. One comment was about using Uber as a transportation method, one comment was about expanding transportation and effecting the waiver funding cap, and two comments were about clarification to the service definition.
ODP Response: ODP is currently working on a Transportation communication that will address questions about this service. Regarding the waiver funding cap with transportation, there is a P/FDS exception.

•One comment was received requesting to allow an Organized Health Care Delivery System to pay for Participant Directed Goods and Services when an individual has no desire to self-direct.
ODP Response: No change to this requirement due to CMS guidance, “The coverage of this service is limited to waivers that incorporate the Budget Authority participant direction opportunity”.

•Six comments were received regarding the annual limit on services provided in the P/FDS waiver and the cap exceptions that will be allowed due to changes in Community Participation Support service rates and/or Transportation Trip zones that became effective on July 1, 2019. One comment requested that the P/FDS annual limit be increased to $40,000. One comment supports the cap exceptions as written. Four comments requested that increasing community time in the Community Participation Support service be added as a reason that a participant can have a cap exception.
ODP Response: No changes were made to section C-4 of the waiver. ODP will continuously analyze and update the limit based on established rates, services authorized on service plans and utilization of those services.

•One comment was received regarding a consideration about Technology First.
ODP Response: This consideration will be considered by the Technology Task Force.

•Three comments recommend that language needs to be updated to note that the Supports Coordination Organization and AE must ensure education and access to Agency with Choice services.
ODP Response: No changes were made based upon these comments. The responsibilities of Supports Coordination Organizations and AEs regarding participant directed services is contained in multiple sections of the waiver including the Supports Coordination service definition, section D-1-d and E-1-a.

•Three comments were received pointing out inconsistencies in the waiver regarding how the Agency with Choice monthly administrative fee is established.

ODP Response: Section E-1-ii has been updated to reflect that the AWC monthly administrative fee is developed by ODP through the fee schedule rate development process.

•Three comments recommended that clarification be provided regarding training for medication administration to ensure compliance with the nurse practice act laws and regulations.
ODP Response: The waivers will align with the 55 Pa. Code Chapter 6100 regulations which were developed through an extensive stakeholder engagement process and were unanimously approved by the Independent Regulatory Review Commission. The regulations and waivers comply with the nurse practice act laws and regulations. The agreement by the Department of State and Department of Human Services, with a ruling by the Governor's Office of General Counsel, is that human service facilities and providers do not hold themselves out as practicing nursing. For this reason, medication administration is not a "nurse practice" and as such it is not regulated under the jurisdiction of the State Nurses Board.

•Three comments were received regarding the rate determination methods in section I-2-a. The comments pointed out an error in the rate assigned to providers that fail to submit a cost report. The comments also assert that ODP has not provided required letters/notices of proposed or final rates nor has ODP communicated the list of fee schedule services and the rates through a public notice prior to the effective date as indicated in section I-2-a.
ODP Response: Section I-2-a has been revised to accurately reflect the process for rate assignment for providers that fail to submit a cost report. The waiver currently states, "Changes and addition of services to the fee schedule are communicated through a public notice published in the Pennsylvania Bulletin prior to the effective date of any change or addition. Fee schedule rates are implemented prospectively… In the future, ODP may use a variety of mechanisms to obtain public comment on rate determination methodologies, including stakeholder workgroup discussions, draft documents distributed for public comment, communications and public meetings." In fiscal year 2018-19, ODP used a stakeholder workgroup to discuss and develop proposed changes to Community Participation Support rates effective in fiscal year 2019-2020. ODP published the proposed rate changes and methodology for Community Participation Support services as well as Transportation Trip for public comment in communication 019-024 on March 6, 2019. This communication stated, "There are no changes proposed to rates for any service other than those outlined in this communication since they were published as final in the Pennsylvania Bulletin Volume 48, Number 4 on Saturday, January 27, 2018. The current rates for all other services are available on the Department of Human Services website at:
http://www.dhs.pa.gov/provider/developmentalprograms/feeschedulerates/index.htm."
ODP then made adjustments to rate assumptions and rates based on public comment received and published the final Community Participation Support rates for public comment in the Pennsylvania bulletin on May 25, 2019. The final Community Participation Support rates became effective on July 1, 2019. Based on public comment received on proposed changes to Transportation Trip services, ODP decided not to implement the changes as final.

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Community Participation Support Service Definition

CPS may be provided at the following staff-to-individual ratios in a licensed facility:
• Basic- 1:11 to 1:15
• Level 1- 1:7 to 1:10
• Level 2- 1:4 to 1:6
• Level 3- 1:2 to 1:3
• Level 4- 1:1
• Level 4 Enhanced- 1:1 with a staff member who is certified, has a bachelor's degree or is a licensed nurse.
• Level 5- 2:1 to 1:1
• Level 5 Enhanced- 2:1 to 1:1 with 1 staff member who is certified, has a bachelor's degree or is a nurse & 1 staff member with at least a high school diploma.

CPS may be provided at the following staff to individual ratios in community locations & community hubs:
• Basic- 1:2 to 1:3
• Level 1- 2:3
• Level 2- 1:1
• Level 2 Enhanced- 1:1 with a staff member who is certified, has a bachelor's degree or is a licensed nurse.
• Level 3- 2:1.
• Level 3 Enhanced- 2:1 with 1 staff member who is certified, has a bachelor's degree or is a nurse & 1 staff member with at least a high school diploma.

The use of Level 4 Enhanced, Level 5 & 5 Enhanced in facility locations as well as Level 2 Enhanced, Level 3 & Level 3 Enhanced are based on the participant's behavioral or medical support needs. The need for these enhanced levels of service must

be reviewed every 6 months in accordance with ODP policy for continued authorization. If a participant requires supplemental staffing during this service, the CPS provider is responsible to provide the staffing.

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

Starting 1/1/22 CPS services may not be provided in any facility required to hold a 2380 or 2390 license that serves more than 150 individuals at any one time including individuals funded through any source.

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

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Remediation strategies for Appendix C Quality Improvement

QP3. Number and percent of providers delivering Participant Directed Services that meet requirements. A provider who has not completed the requalification process by January 31st is disenrolled by the ODP Provider Enrollment Unit. If a provider sends in a requalification packet after being disenrolled, the provider will be considered a new provider and will have to enroll as such. ODP tracks this process through the partnership with the VF/EA FMS Contractor. Providers (SSPs) who do not complete the requalification process or who by and through the process are found to no longer qualify may not render an HCBS after the date their current qualifications expire. If a provider sends in a requalification packet after being disenrolled, the provider will have to complete an initial enrollment packet as if they were a newly enrolled SSP. This process is administered by the FMS agent, which sends reports to ODP documenting each SSP’s qualification status. ODP can then verify that only qualified providers are providing HCBS.

QP4. Number and percent of providers that meet training requirements in accordance with state requirements in the approved waiver. Through ODP's QA&I Process, ODP or AEs conduct on-site reviews of 100% of SCO, providers (with the exception of public transportation providers) and AWCs on a 3-year cycle using the standardized monitoring tools developed by ODP. For SCOs, ODP reviews the training records for Supports Coordinators and Supports Coordinator Supervisors to determine that they attended and completed all required trainings. For providers, if the required staff training is not documented in the record, ODP or the AE will notify the provider and the provider must locate missing documentation or ensure that training is provided within 30 days. The remediation for this process will occur as outlined in the ODP established corrective action process.

## 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.

Department of Human Services, Office of Developmental Programs (ODP)

*(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:

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The Deputy Secretary of the Office of Developmental Programs (ODP) reports directly to the Secretary of Human Services. The Secretary of Human Services is the head of the single state Medicaid agency. ODP is an office within the Department of Human Services (Department). The Secretary of Human Services, the State Medicaid Director (Deputy Secretary of the Office of Medical Assistance Programs) and the Deputy Secretary of the Office of Developmental Programs meet regularly to discuss operations of the Waivers and other long term living programs. Therefore, the State Medicaid Agency through the Secretary of Human Services has ultimate authority over operations of the Waiver. The roles and responsibilities of the operating divisions within the Department, including ODP and OMAP, are outlined on the following Department of Human Services website: http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/index.htm.

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

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

**3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

## Appendix A: Waiver Administration and Operation

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

- ○ **Not applicable**
- ◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
  Check each that applies:
  - ☒ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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The Office of Developmental Programs (ODP) has an agreement with County Mental Health/Intellectual Disability (MH/ID) programs under the control of local elected officials to perform delegated waiver and operational administrative functions. The 55 Pa. Code Chapter 51 regulations or its regulatory successor authorize Department Designees, Administrative Entities (AEs), to perform waiver administrative functions. Each of these public agencies are delegated functions through an AE Operating Agreement. The AE implements these responsibilities and meets the requirements specified in the AE Operating Agreement.

AEs perform the following delegated waiver administration functions:

1. Participant waiver enrollment – Receive/review applications, ensure initial and annual completion of PUNS or its successor and refer applicants for an eligibility decision. AEs must plan to enroll individuals who will graduate from special education each year and who are not eligible to continue their education through the next year in a waiver that will ensure their health and safety needs are met.

2. Level of care (LOC) determination – Compile necessary documentation for a LOC determination, review documentation and make a determination regarding whether the applicant/participant meets LOC criteria.

3. Review of service plans – Includes review, clarification and approval of service plans.

4. Qualified provider enrollment – Provider recruitment.

5. Quality assurance and improvement activities – Conduct qualified provider reviews, oversee provider corrective action plans, refer providers to ODP for sanctions and/or disqualification.

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

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

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

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When a County MH/ID program is unwilling or unable to perform AE functions, ODP will select a non-governmental entity to perform delegated functions. ODP may select a multi-county MH/ID program or non-profit entity. The 55 Pa. Code Chapter 51 regulations or its regulatory successor authorize Department Designees, Administrative Entities (AEs), to perform waiver administrative functions. These public agencies are delegated functions through an AE Operating Agreement. The AE implements these responsibilities and meets the requirements specified in the AE Operating Agreement. A non-governmental entity designated as an AE is delegated the same operational and administrative functions delegated to public agencies.

ODP also retains the authority for all administrative decisions and the oversight of non-governmental entities that conduct Waiver operational and administrative functions. ODP retains authority over the administration of the P/FDS Waiver, including the development of Waiver related policies, rules, and regulations. Regulations, Waiver policies, rules and guidelines are distributed by ODP through bulletins and other communications issued electronically.

## Appendix A: Waiver Administration and Operation

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

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

## Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

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ODP assesses the performance of AEs through the Quality Assessment and Improvement (QA&I) process. Using a standard review tool, ODP gathers data to assess AE performance in carrying out delegated functions. ODP requires the AE to complete a Corrective Action Plan (CAP) for any item that is assessed with a compliance score below 86%. ODP may require the AE to complete a Directed Corrective Action Plan (DCAP) in the following circumstances:

• When an AE has more than one item in any area that is assessed below 86%;

• If an AE has serious or recurring deficiencies.

When an AE fails to meet the requirements of a DCAP or if there are serious and persistent deficiencies ODP may terminate the AE Operating Agreement.

ODP monitors AEs on a three year cycle. During that period, ODP gathers AE performance data annually on one-third of AEs. During the cycle the AE must complete a self-assessment in accordance with the ODP Oversight Process. The AE self-assessment is reviewed and validated by ODP.

## Appendix A: Waiver Administration and Operation

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

| Function | Medicaid Agency | Local Non-State Entity |
|---|---|---|
| **Participant waiver enrollment** | ☒ | ☒ |
| **Waiver enrollment managed against approved limits** | ☒ | ☒ |
| **Waiver expenditures managed against approved levels** | ☒ | ☐ |
| **Level of care evaluation** | ☒ | ☒ |
| **Review of Participant service plans** | ☒ | ☒ |
| **Prior authorization of waiver services** | ☒ | ☐ |
| **Utilization management** | ☒ | ☐ |
| **Qualified provider enrollment** | ☒ | ☒ |

| Function | Medicaid Agency | Local Non-State Entity |
|---|---|---|
| **Execution of Medicaid provider agreements** | ☒ | ☐ |
| **Establishment of a statewide rate methodology** | ☒ | ☐ |
| **Rules, policies, procedures and information development governing the waiver program** | ☒ | ☐ |
| **Quality assurance and quality improvement activities** | ☒ | ☒ |

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

**a. Methods for Discovery: Administrative Authority**

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

**i. Performance Measures**

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

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

***Where possible, include numerator/denominator.***

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

**Performance Measure:**
**AA1 - Number and percent of waiver openings distributed equitably across all geographic areas covered by the waiver using criteria identified in Appendix B-3. Numerator = number of waiver openings distributed equitably across all geographic areas covered by the waiver using criteria identified in Appendix B-3. Denominator = number of waiver openings distributed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Waiver Capacity Distribution 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** | ☐ **Weekly** | ☒ **100% Review** |

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

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

**Performance Measure:**
**AA2-Number and percent of eligible applicants having an emergency need or who have been identified as being in reserved capacity status who receive preference in waiver enrollment. Numerator=number of eligible applicants having an emergency need or who have been identified as being in reserved capacity status who receive preference in waiver enrollment. Denominator=number of eligible applicants.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Waiver Capacity Management Reports**

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☒ **Other**<br>Specify:<br>Semi-Annually |

**Performance Measure:**
**AA3 - Number and percent of participants issued fair hearing and appeal rights in accordance with policies and procedures. Numerator = number of participants issued fair hearing and appeal rights in accordance with policies and procedures. Denominator = number of participants reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Participant Record Review**

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

| | | |
|---|---|---|
| | | Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95% |
| ☐ **Other** Specify: | ☒ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**AA4 - Number and percent of AEs that qualify providers using qualification criteria as outlined in the current approved waiver. Numerator = number of AEs that qualify providers using qualification criteria as outlined in the current approved waiver. Denominator = number of AEs reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**ODP QA&I Process 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**
**AA5 - Number and percent of AEs that monitor providers using the standard tool and monitoring processes developed by ODP. Numerator = number of AEs that monitor providers using the standard tool and monitoring processes developed by ODP. Denominator = number of AEs reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA&I Process 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>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.

---

AA1. The Department calculates and distributes waiver openings based on the current enrollment in the AE's jurisdiction and expected need for access based on a review of the PUNS or its successor across the state.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

---

AA1. Number and percent of waiver openings distributed equitably across all geographic areas covered by the waiver using criteria identified in Appendix B-3. If it is discovered that an error in calculation was made, the Department will revise the distribution accordingly to reflect the correct calculation.

AA2. ODP reviews on a bi-weekly basis reports for individuals added to Intent to Enroll status (individuals who are in the process of being enrolled in the Waiver) to ensure that eligible applicants having an emergency need for services or who have been identified as being in reserved capacity status receive preference in waiver enrollment. For any individual who does not have emergency status on the waiting list or has not been identified as being in reserved capacity status, ODP reviews the record and/or contacts the AE to determine if the eligible applicant meets emergency criteria or reserved capacity status. The AE is instructed to update the record as necessary and appropriate. If ODP determines that the individual does not meet emergency or reserved capacity status criteria, ODP will provide technical assistance/training to the AE regarding ODP's waiver enrollment policies. An AE that continues to fail to make the required corrections or updates to the record or to violate waiver enrollment policies will be suspended from making waiver enrollment decisions for a period of 90 days unless otherwise sanctioned by ODP. All requests for enrollment during the suspension period will be processed through an ODP Regional Office.

AA3. Number and percent of waiver participants issued fair hearing and appeal rights in accordance with policies and procedures. Through ODP’s QA&I Process, ODP determines if participants in the sample were issued rights to fair hearing and appeals when the participant was determined likely to require ICF/ID or ICF/ORC level of care (for participants enrolled within the last twelve months)and at the time of a service change (if a service was reduced, suspended, terminated or denied). If ODP does not locate documentation to substantiate that due process rights were issued in the above circumstances, ODP will instruct the AE to locate missing documentation or, when not available, provide written notification of due process rights to the participant/surrogate. The information is recorded in HCSIS or the service plan Signature Page is completed where applicable with a note acknowledging that the notification is late. If a participant’s record indicates more than one instance in which notification of due process rights was not issued, the AE may provide to the participant a one-time written notification that includes an explanation for each instance late. The AE is expected to document remediation actions and submit the documentation to ODP within 30 days.

AA4. Number and percent of AEs that qualify providers using qualification criteria as outlined in the current approved Waiver. Through ODP's QA&I Process, ODP reviews a sample of provider initial and annual provider qualification applications. ODP ensures that each AE reviews provider qualification information using ODP standardized procedures. If the AE does not qualify a provider using ODP standardized procedures, the AE is expected to contact the provider and collect all missing documents within 30 days. If the documentation obtained does not corroborate that the provider meets qualification standards, the provider will be prohibited from receiving payments for waiver services. ODP will provide training to the AE on the correct application of the provider qualification process. ODP will enhance its monitoring of the AE and if the problem persists, initiate sanctions as specified in the AE Operating Agreement.

AA5. Number and percent of AEs that monitor providers using the standard tool and monitoring processes developed by ODP. ODP identifies annually the providers to be monitored using the ODP standardized monitoring process and tool. Upon completion of monitoring for each provider, the AE will complete and submit the standardized monitoring tool to ODP. Through ODP's QA&I Process, ODP reviews a sample of providers monitored by each AE. If the AE does not complete provider monitoring using the monitoring processes developed by ODP, the AE will remediate identified deficiencies and notify ODP of the completion of remediation actions within 30 days.

For any of the above Administrative Authority Performance Measures, the Department will initiate actions as needed to resolve any outstanding issues with AE performance using the methodology outlined in the AE Operating Agreement.

**ii. Remediation Data Aggregation**

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

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

**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** | | | ☐ |

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| | ☐ | Medically Fragile | | | ☐ |
| | ☐ | Technology Dependent | | | ☐ |
| ☒ Intellectual Disability or Developmental Disability, or Both | | | | | |
| | ☒ | Autism | 0 | | ☒ |
| | ☒ | Developmental Disability | 0 | 21 | ☐ |
| | ☒ | Intellectual Disability | 0 | | ☒ |
| ☐ Mental Illness | | | | | |
| | ☐ | Mental Illness | | | ☐ |
| | ☐ | Serious Emotional Disturbance | | | |

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

Individuals residing in licensed and unlicensed residential habilitation settings which include Community Homes for Individuals with Intellectual Disabilities, Family Living Homes, Child Residential Facilities, and Community Residential Rehabilitation Services are excluded from enrollment in the P/FDS Waiver.

Residents of licensed Assisted Living Residences are excluded from enrollment in the P/FDS Waiver.

Individuals residing in licensed Personal Care Homes (55 Pa. Code Chapter 2600) with eight (8) or more residents with a move-in date for the Personal Care Home of July 1, 2008 or after are excluded from enrollment in the P/FDS Waiver. The move-in date applies to the Personal Care Home where the person is residing as of July 1, 2008 and may not be transferred to a new home.

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

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

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

*Specify:*

Participants who are enrolled with a developmental disability with a high probability of resulting in an intellectual disability or autism will be reevaluated using the ICF/ID criteria for an intellectual disability or ICF/ORC criteria for a diagnosis of autism during their 8th year (prior to their 9th birthday). If they are eligible, they will continue to receive waiver services. If the participant is not eligible, he or she will be referred to other resources. Individuals will be referred to the Office of Children, Youth and Families as applicable and the Office of Mental Health and Substance Abuse Services.

Individuals who have a developmental disability due to a medically complex condition have the option to enroll in the waiver only if they are age 0 to 21. Once a participant reaches age 22, the participant will be given the option to remain enrolled in the waiver after age 22 or transition to another program.

## Appendix B: Participant Access and Eligibility

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

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

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage: [ ]

  - ( ) **Other**

    *Specify:*

    [ ]

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

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

  [ ]

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

  - ( ) **The following dollar amount:**

    Specify dollar amount: [ ]

    **The dollar amount** *(select one)*

    - ( ) **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

      [ ]

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

  - ( ) **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| **Year 1** | |

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| | 15490 |
| Year 2 | 15490 |
| Year 3 | 15490 |
| Year 4 | 15490 |
| Year 5 | 15490 |

**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 | 14200 |
| Year 2 | 14200 |
| Year 3 | 14200 |
| Year 4 | 14200 |
| Year 5 | 14200 |

## 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 | |
|---|---|
| Graduate Waiting List Initiative | |
| Competitive Employment Initiative | |
| Hospital/Rehabilitation Care | |
| Participant Direction Transfers | |

## 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):*

Graduate Waiting List Initiative

**Purpose** *(describe):*

ODP has reserved capacity in Years 1 through 5 for the waiting list initiative to serve students graduating from special education who are not eligible to continue their education through the next year. In accordance with ODP policy as enumerated in Appendix A, any new individual identified for enrollment must be identified as having an emergency need. The students identified for the waiting list initiative may not meet this requirement which makes it necessary to reserve capacity for them to ensure they have access to the waiver.

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 criteria for emergency status in PUNS or its successor. This is evidenced by the service plan process that is required for all participants and requires that service options be promoted and fully explored with every participant.

**Describe how the amount of reserved capacity was determined:**

Reserved capacity has been determined by the historical number of individuals who have graduated from special education and who are not eligible to continue their education through the next year. The capacity is reserved to the extent that resources have been identified to support it.

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

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 820 |
| Year 2 | 700 |
| Year 3 | 700 |
| Year 4 | 700 |
| Year 5 | 700 |

## 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):*

Competitive Employment Initiative

**Purpose** *(describe):*

ODP reserves capacity for individuals who are transitioning out of OVR with a competitive integrated job to encourage competitive employment.

In accordance with ODP policy as enumerated in Appendix A, any new individual identified for enrollment must be identified as having an emergency need. The individuals identified for the competitive employment initiative may not meet this criteria which makes it necessary to reserve capacity for them to ensure that they have access to the waiver.

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 criteria for emergency status in PUNS or its successor. This is evidenced by the service plan process that is required for all participants and requires that the service options be promoted and fully explored with every individual.

**Describe how the amount of reserved capacity was determined:**

This initiative allows ODP to support approximately 50 individuals in Year 1 who have or expect to have a successful OVR closure. The capacity is reserved to the extent that resources have been identified to support it.

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

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 50 |
| Year 2 | 0 |
| Year 3 | 0 |
| Year 4 | 0 |
| Year 5 | 0 |

## Appendix B: Participant Access and Eligibility

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

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

Hospital/Rehabilitation Care

**Purpose** *(describe):*

ODP reserves waiver capacity for participants requiring:

• Hospital care beyond 30 consecutive days and up to 6 consecutive months from the first date of leave when they are not receiving any waiver services during that time; or

•Rehabilitation care beyond 30 consecutive days and up to 6 consecutive months from the first date of leave.

Waiver capacity will be reserved for participants requiring hospital or rehabilitation care in the following settings: medical and psychiatric hospital settings, rehabilitation care programs and nursing homes. Waiver capacity will not be reserved for participants requiring hospital or rehabilitation care in the following settings: residential treatment facilities, state mental health hospitals, approved private schools and private and state ICFs/ID.

**Describe how the amount of reserved capacity was determined:**

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

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

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 25 |
| Year 2 | 25 |
| Year 3 | 25 |
| Year 4 | 25 |
| Year 5 | 25 |

## 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):*

Participant Direction Transfers

**Purpose** *(describe):*

This capacity is reserved to ensure individuals enrolled in all ODP administered waivers have the opportunity to self-direct their services. ODP will reserve capacity for participants who are planning to self-direct the majority of their waiver services to transfer into this waiver from any ODP administered waiver that does not provide participant directed services options.

**Describe how the amount of reserved capacity was determined:**

The amount of reserved capacity was estimated based on inquiries from people in waivers that do not provide participant directed service options and historical use in ODP waivers with participant directed service options.

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

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 0 |
| Year 2 | 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:

---

The Department calculates and distributes waiver openings to the AEs based on the current enrollment in the AE and expected need for access based on a review of the PUNS or its successor across the state. The distribution method is reviewed annually.

AEs are responsible to ensure PUNS(or its successor)information is current. In accordance with the AE Operating Agreement, if unused capacity exists with an AE, the capacity may be held and authorized at the state level and/or the state may commit the unused capacity to another AE based on need. Additionally, ODP may commit additional capacity to an AE based on unanticipated emergencies as defined in ODP policy.

The AE is responsible to evaluate the PUNS(or its successor)categorization of a Waiver applicant when making enrollment decisions. Waiver applicants assessed by the AE must meet the criteria for emergency status in PUNS (or its successor)or be in reserved capacity status to be enrolled in the Waiver. ODP retains ultimate authority to select individuals for Waiver enrollment based on an individual's unique emergency circumstances. The Department reserves the right to adjust the number of participants in the AE's Waiver Capacity Commitment in either Waiver based on utilization or other considerations.

Participants may choose to receive services from a qualified and willing provider anywhere in Pennsylvania or a state contiguous to Pennsylvania as permitted in Appendix C of this Waiver. P/FDS Waiver services are accessible statewide. If a participant is enrolled in the Waiver and chooses to relocate to a different county, the county where the participant resides has two options: 1) the county may choose to continue to provide administrative services to the participant in accordance with the AE Operating Agreement; or 2) the county may choose to transfer this responsibility and corresponding waiver capacity to the county where the participant is moving. If the second option is chosen the receiving county must accept the participant's transfer. The participant's service plan and Waiver effective date will not be affected by the transfer.

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

---

The AE is responsible to identify an individual for Waiver enrollment when capacity becomes available. Services should begin within 45 calendar days of the Waiver enrollment date, unless otherwise indicated in the service plan (e.g. participant's choice of provider delays service start, participant's medical or personal situation impedes planned start date). Any delays in the initiation of a service after 45 calendar days must be discussed with the participant and agreed to by the participant. ODP policy specifies that Waiver enrollment must be offered to individuals most in need as identified by the waiting list needs assessment status (emergency) or reserved capacity status. ODP retains ultimate authority to select individuals for Waiver enrollment based on an individual's emergency circumstances.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

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

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

**2. Miller Trust State.**

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

- (●) **No**
- ( ) **Yes**

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

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

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

  *Select one*:

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

    Specify percentage: [ ]

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

  *Specify:*

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

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

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

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

*Select one and complete Appendix B-5.*

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

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

*Check each that applies*:

☒ **A special income level equal to:**

*Select one*:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

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

☐ **Aged and disabled individuals who have income at:**

*Select one*:

○ **100% of FPL**

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

Specify percentage amount:

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

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

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

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).*

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

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

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

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
*(Complete Item B-5-b (SSI State) and Item B-5-d)*

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

◉ **The following standard included under the state plan**

*Select one*:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

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

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

  Specify dollar amount:

( ) **A percentage of the Federal poverty level**

Specify percentage:

( ) **Other standard included under the state Plan**

*Specify:*

( ) **The following dollar amount**

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

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

*Specify:*

( ) **Other**

*Specify:*

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

(●) **Not Applicable**

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

*Specify:*

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

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

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

○ **The amount is determined using the following formula:**

*Specify:*

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

*Specify:*

○ **Other**

*Specify:*

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

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

Select one:

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

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

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

# Appendix B: Participant Access and Eligibility

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

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

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

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

**i. Allowance for the personal needs of the waiver participant**

(*select one*):

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

  Specify percentage:
- ○ **The following dollar amount:**

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

  *Specify formula:*
- ○ **Other**

  *Specify:*

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

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

*Explanation of difference:*

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

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

Select one:

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

○ **The state does not establish reasonable limits.**

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

# Appendix B: Participant Access and Eligibility

## B-6: Evaluation/Reevaluation of Level of Care

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

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

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

---

Individuals determined to need waiver services must require the following:
1. Provision of at least one waiver service, excluding Supports Coordination.
2. Waiver services provided 2 times per year at minimum.

Monitoring of participants requirements conducted by Supports Coordination can be found in Appendix D-2-a of this waiver.

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

- ◉ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By a government agency under contract with the Medicaid agency.**

*Specify the entity:*

- ○ **Other**

*Specify:*

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

---

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

The QDDP must have one of the following:

• A master’s degree or higher level of education from an accredited college or university and one year of work experience working directly with persons with developmental disabilities;

• A bachelor’s degree from an accredited college or university and two years work experience working directly with persons with developmental disabilities; or

• An associate’s degree or 60 credit hours from an accredited college or university and four years work experience working directly with persons with developmental disabilities.

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

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

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

---

The AEs are responsible for the completion of an evaluation of need for level of care, and timely renewal annually thereafter. The initial evaluation and any reevaluation will be performed by a qualified professional.

1. ICF/ID

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

1. Have a diagnosis of intellectual disability. Eligibility criteria is defined as the following: a diagnosis of intellectual disability based on the results of a standardized intellectual psychological testing, which reflects a full scale score of 70 and below (based on 2 or more standard deviations below the mean); and

2. Intellectual disability occurred prior to age 22; and

3. Substantial adaptive skills deficits in three or more areas of major life activity: self-care, understanding and use of language, learning, mobility, self direction and/or capacity for independent living based on a standardized adaptive functioning test; and

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

2. Autism ICF/ORC

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

1. Have a diagnosis of autism. Eligibility criteria is defined as a diagnosis of autism based on the results of a diagnostic tool; and

2. Autism occurred prior to age 22; and

3. Substantial adaptive skills deficits in three or more areas of major life activity: self-care, understanding and use of language, learning, mobility, self direction and/or capacity for independent living based on a standardized adaptive functioning test; and

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

3. Developmental Disability with a high probability of intellectual disability or autism prior to age 9 ICF/ORC

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

1. Have a diagnosis of developmental disability. Eligibility criteria is defined as the following: developmental disability which is defined as a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in an intellectual disability or autism, the disability manifested prior to the age of 9 and the disability is likely to continue indefinitely; and

2. Individual is 8 years old or younger; and

3. Substantial adaptive skills deficits in three or more areas of major life activity: self-care, understanding and use of language,

learning, mobility, self direction and/or capacity for independent living based on a standardized adaptive functioning test; and

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

4. Developmental Disability due to a medically complex condition prior to age 22 ICF/ORC

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

1. Have a medically complex condition defined as one or more chronic health conditions that meet both of the following: (a)
cumulatively affect three or more organ systems; and (b) require medically necessary nursing intervention to execute medical
regimens to use technology for respiration, nutrition, medication administration or other bodily functions;

2. Individual is 21 years of age or younger;

3. Have substantial adaptive skills deficits in three or more areas of major life activity: self-care, understanding and use of
language, learning, mobility, self-direction and/or capacity for independent living based on a standardized adaptive functioning test;

and

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

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

---

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

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

1. A licensed psychologist, certified school psychologist, psychiatrist, or licensed physician (which includes a developmental pediatrician) certifies that the individual has significantly sub-average intellectual functioning which is documented by either:
a. Performance that is more than two standard deviations below the mean of a standardized general intelligence test (70 IQ or below); or

b. Performance that is slightly above two standard deviations below the mean of a standardized general intelligence test during a period
when the person manifests serious impairments of adaptive functioning.

2. A QDDP certifies that the individual has impairments in adaptive behavior based on the results of a standardized assessment of adaptive functioning which shows that the individual has both of the following:

a. Significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility of his or
her age and cultural group; and

b. Substantial adaptive skill deficits in three or more areas of major life activity: self-care, understanding and use of language,
learning, mobility, self-direction and/or capacity for independent living based on a standardized adaptive functioning test.

3. Documentation substantiates that the individual has had these conditions of intellectual and adaptive functioning deficits which manifested during the developmental period which is from birth up to the individual’s 22nd birthday.

4. The results of a medical evaluation completed within the previous 365 days that reflects the individual’s current medical condition. The medical evaluation may be the medical evaluation approved by the Department (Form MA 51), or an examination that is completed by a licensed physician, physician’s assistant, or nurse practitioner that states the individual is recommended for an ICF/ID level of care.

The following four criteria must be met to document a diagnosis of autism and determine eligibility upon initial certification:

1. A licensed psychologist, certified school psychologist, psychiatrist, developmental pediatrician, licensed physician, licensed physician assistant or licensed nurse practitioner certifies that the individual has a diagnosis of autism which is documented by the results of a diagnostic tool.

2. A QDDP certifies that the individual has impairments in adaptive behavior based on the results of a standardized assessment of adaptive functioning which shows that the individual has both of the following:

a. Significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility of his or
her age and cultural group; and

b. Substantial adaptive skill deficits in three or more areas of major life activity: self-care, understanding and use of language,

learning, mobility, self-direction and/or capacity for independent living based on a standardized adaptive functioning test.

3. Documentation substantiates that the individual has had these conditions of autism and adaptive functioning deficits which manifested during the developmental period which is from birth up to the individual's 22nd birthday.

4. The results of a medical evaluation completed within the previous 365 days that reflects the individual's current medical condition. The medical evaluation may be the medical evaluation approved by the Department (Form MA 51), or an examination that is completed by a licensed physician, physician's assistant, or nurse practitioner that states the individual is recommended for an ICF/ORC level of care.

The following four criteria must be met to document a diagnosis of developmental disability with a high probability of resulting in an intellectual disability or autism and determine eligibility upon initial certification:

1. A licensed psychologist, certified school psychologist, psychiatrist, developmental pediatrician, licensed physician, licensed physician assistant or licensed nurse practitioner certifies that the individual has a diagnosis of developmental disability with a high probability of resulting in an intellectual disability or autism which is documented by the results of a standardized diagnostic tool.

2. A QDDP certifies that the individual has impairments in adaptive behavior based on the results of a standardized assessment of adaptive functioning which shows that the individual has both of the following:

a. Substantial adaptive skill deficits in three or more areas of major life activity: self-care, understanding and use of language,
learning, mobility, self-direction and/or capacity for independent living based on a standardized adaptive functioning test.

3. The individual is 8 years of age or younger.

4. The results of a medical evaluation completed within the previous 365 days that reflects the individual's current medical condition. The medical evaluation may be the medical evaluation approved by the Department (Form MA 51), or an examination that is completed by a licensed physician, physician's assistant, or nurse practitioner that states the individual is recommended for an ICF/ORC level of care.

The following four criteria must be met to document a diagnosis of a medically complex condition and determine eligibility upon initial certification:

1. A licensed physician, including a developmental pediatrician, licensed physician's assistant or certified registered nurse practitioner must certify on DP 1090 that the individual has a medically complex condition.

2. A QDDP certifies that the individual has impairments in adaptive behavior based on the results of a standardized assessment of adaptive functioning which shows that the individual has both of the following:

a. Significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility of his or
her age and cultural group; and

b. Substantial adaptive skill deficits in three or more areas of major life activity: self-care, understanding and use of language,
learning, mobility, self-direction and/or capacity for independent living based on a standardized adaptive functioning test.

3. The individual is 21 years of age or younger.

4. The results of a medical evaluation completed within the previous 365 days that reflects the individual's current medical condition. The medical evaluation may be the medical evaluation approved by the Department (Form MA 51), or

an examination that is completed by a licensed physician, physician's assistant, or nurse practitioner that states the individual is recommended for an ICF/ORC level of care.

The following process for level of care recertification must be met annually:

The reevaluation of need for an ICF/ID or ICF/ORC level of care is to be made within 365 days of the individual's initial evaluation or reevaluation.

The QDDP must recertify that the individual continues to require an ICF/ID or ICF/ORC level of care in accordance with the criteria outlined in appendix B-6-d. The reevaluation is based on an assessment of the individual's current social, psychological, and physical condition, as well as the individual's continuing need for home and community based services. An individual shall meet the criteria for eligibility only when a QDDP, based on review of the individual's social and psychological history, determines that the individual will benefit from a professionally developed and supported program of activities, experiences or therapies. If the assessment indicates significant improvement, the individual's level of care will be determined using the initial level of care process.

All individuals require annual reevaluation of need for an ICF/ID or ICF/ORC level of care to continue to qualify for services funded under the Waiver.

**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):*

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In accordance with the AE Operating Agreement, the AE is responsible to complete the reevaluation of need for an ICF/ID or ICF/ORC level of care within 365 days of the participant's initial evaluation and subsequent anniversary dates of reevaluations. The reevaluation shall be completed an assessment by a QDDP and shall be based on the participant's continuing need for an ICF/ID or ICF/ORC level of care, his/her progress toward meeting plan outcomes, the content of the service plan, continued need for supports provided through the waiver and consideration of alternate methods of care.

**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:

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Records are maintained at the AE office where the participant is registered, as per the AE Operating Agreement

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**
**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 a LOC completed prior to entry into the waiver. Denominator = number of new enrollees.**

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

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

| | | |
|---|---|---|
| | | Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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:**
**LOC2 - Number and percent of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver is used. Numerator = number of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver is used. Denominator = number of initial LOC determinations.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Participant Record Review**

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

| | | |
|---|---|---|
| | | Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95% |
| ☐ **Other** Specify: | ☒ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

**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.

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

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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LOC1. On a monthly basis, ODP generates and distributes to the specific AE, HCSIS reports identifying initial level of care compliance and noncompliance data. The reports include a list of exceptions for that AE (any individual for whom a level of care evaluation is not entered into HCSIS as completed prior to the waiver start date). The AE is responsible to review these reports and provide remediation for any situation where a level of care has not been completed prior to waiver enrollment. Remediation will include completion of level of care documents and/or data entered into HCSIS. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification. If the level of care evaluation results in a finding that the participant is not eligible, the participant will be disenrolled from the Waiver and referred to other appropriate resources and payment for any waiver services provided will be recouped. The Department will initiate actions as needed to resolve any outstanding issues with AE performance using the methodology outlined in the AE Operating Agreement.

LOC2. Number and percent of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver is used. ODP evaluates whether initial level of care determinations are completed accurately according to ODP policies and procedures. The AE must complete level of care evaluations using ODP's forms and processes. The AE is required to document remediation actions and submit the documentation to ODP within 30 days. When documentation is located or completed and eligibility in any one of the criteria is not met, disenrollment procedures will be initiated per ODP policies and procedures. If a determination is made that an AE is incorrectly applying the criteria and making determinations that are incorrect, targeted technical assistance is provided to the AE in order to ensure they fully understand the process and apply it correctly. The Department will initiate actions as needed to resolve any outstanding issues with AE performance using the methodology outlined in the AE Operating Agreement.

**ii. Remediation Data Aggregation**

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

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

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

**c. Timelines**

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

The AE is required to assure that all individuals requesting services who are likely to require an ICF/ID or ICF/ORC level of care, or their legal representatives, are informed of feasible home and community-based services funded under the waiver. Feasible alternatives include sufficient and appropriate home and community-based services and support that the individual needs or is likely to need in his or her home and community. This requirement must be met before an individual is given the choice of service delivery preference to receive Medicaid funded services in an institutional setting or home and community based services prior to waiver enrollment.

The AE is required to ensure that the waiver participant is free to choose services in any Pennsylvania county. ODP currently utilizes standard forms to document requests for waiver services or changes in waiver services and service delivery preference.

**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.

ODP currently utilizes standard forms to document requests for waiver services or changes in waiver services and service delivery preference. Completed forms are maintained at the AE offices where the participant is registered, as per the AE Operating Agreement.

## 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):

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Each AE is required to provide accommodations to any individual/participant enrolled or enrolling with an AE while performing their administrative functions. Accommodations include but are not limited to: oral interpretation, written translation and language lines. AEs are also required to have and implement policies/procedures for ensuring language assistance services to people who have limited proficiency in English, in accordance with Title VI and corresponding ODP policy.

The policies/procedures must include a statement noting that each participant will be assessed regarding their proficiency in the English language; that documentation will be maintained in the participant's record indicating the participant's need for language assistance and the resources utilized to provide this assistance; the assessment of language assistance resources and the development of a resource bank accessible to all staff members needing to provide services to a person with limited English proficiency; a procedure for ongoing staff training; and a procedure for monitoring compliance with Title VI, which can be part of the AE's quality management strategy.

# 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** | **Community Participation Support** | | |
| **Statutory Service** | **Education Support Services** | | |
| **Statutory Service** | **Family Medical Support Assistance** | | |
| **Statutory Service** | **Homemaker/Chore** | | |
| **Statutory Service** | **In-Home and Community Support** | | |
| **Statutory Service** | **Respite** | | |
| **Statutory Service** | **Supported Employment** | | |
| **Statutory Service** | **Supports Coordination** | | |
| **Extended State Plan Service** | **Specialized Supplies** | | |
| **Extended State Plan Service** | **Therapy Services** | | |
| **Supports for Participant Direction** | **Supports Broker Services** | | |
| **Other Service** | **Advanced Supported Employment** | | |
| **Other Service** | **Assistive Technology** | | |
| **Other Service** | **Behavioral Support** | | |
| **Other Service** | **Benefits Counseling** | | |
| **Other Service** | **Communication Specialist Services** | | |
| **Other Service** | **Companion** | | |
| **Other Service** | **Consultative Nutritional Services** | | |
| **Other Service** | **Family Medical Support Assistance** | | |
| **Other Service** | **Family/Caregiver Training and Support** | | |
| **Other Service** | **Home Accessibility Adaptations** | | |
| **Other Service** | **Housing Transition and Tenancy Sustaining Service** | | |
| **Other Service** | **Music Therapy, Art Therapy and Equine Assisted Therapy** | | |
| **Other Service** | **Participant-Directed Goods and Services** | | |
| **Other Service** | **Shift Nursing** | | |
| **Other Service** | **Small Group Employment** | | |
| **Other Service** | **Transportation** | | |
| **Other Service** | **Vehicle Accessibility Adaptations** | | |

# 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):**

Community Participation Support

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 04 Day Services | 04010 prevocational services |
| **Category 2:** | **Sub-Category 2:** |
| 04 Day Services | 04020 day habilitation |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Community Participation Support (CPS) provides opportunities and support for community inclusion and building interest in and developing skills and potential for competitive integrated employment. CPS should result in active, valued participation in a broad range of integrated activities that build on the participant's interests, preferences, gifts, & strengths while reflecting his or her desired outcomes related to employment, community involvement & membership. To achieve this, each participant must be offered opportunities & needed support to participate in community activities that are consistent with the individual’s preferences, choices and interests.

CPS is intended to flexibly wrap around or otherwise support community life secondary to employment, as a primary goal. This service involves participation in integrated community settings, in activities that involve persons without disabilities who are not paid or unpaid caregivers.

This service is expected to result in the participant developing & sustaining a range of valued social roles & relationships; building natural supports; increasing independence; increasing potential for employment; and experiencing meaningful community participation & inclusion. Activities include the following supports for:
• Developing skills & competencies necessary to pursue competitive integrated employment;
• Participating in community activities, organizations, groups, or clubs to develop social networks;
• Identifying and participating in activities that provide purpose & responsibility;
• Fine and gross motor development & mobility;
• Participating in community opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health & wellness (yoga class, hiking group, etc.);
• Participating in volunteer opportunities or community adult learning opportunities;
• Opportunities focused on training & education for self-determination and self-advocacy;
• Learning to navigate the local community, including learning to use public/private transportation & other transportation options available in the local area;
• Developing and/or maintaining social networks & reciprocal relationships with members of the broader community (neighbors, coworkers, and other community members who do not have disabilities & who are not paid or unpaid caregivers) through natural opportunities & invitations that may occur;
• Assisting participants, caregivers, & providers with identifying and utilizing supports not funded through the waiver that are available from community service organizations, such as churches, schools, colleges/universities & other post-secondary institutions, libraries, neighborhood associations, clubs, recreational entities, businesses & community organizations focused on exchange of services (e.g time banks); and
• Assisting participants & caregivers with providing mutual support to one another (through service/support exchange) & contributing to others in the community.

Direct Community Participation Support may be provided using remote technology in homes where participants reside in accordance with ODP policy. Remote technology cannot be used to provide enhanced levels of Community Participation Support because direct in-person assistance is required.

The service includes planning & coordination for:
• Developing skills & competencies necessary to pursue competitive integrated employment;
• Promoting a spirit of personal reliance & contribution, mutual support & community connection;
• Developing social networks & connections within local communities;
• Emphasizing, promoting & coordinating the use of unpaid supports to address participant & family needs in addition to paid services; and
• Planning & coordinating a participant's daily/weekly schedule for CPS.

Support provided may include development of a comprehensive analysis of the participant in relation to following:
• Strongest interests & personal preferences.
• Skills, strengths, & other contributions likely to be valuable to employers or the community.
• Conditions necessary for successful community inclusion and/or competitive integrated employment.

For participants age 18 and older, fading of the service and less dependence on paid support for ongoing participation in community activities & relationships is expected. Fading strategies, similar to those used in Supported Employment should be utilized whenever appropriate. Effective 10/1/19, on-call and remote support is covered for participants for whom the provider has coordinated community activities in which the participant is supported through unpaid supports and/or as a component of the fading strategy where on-call and remote support is needed as a back-up. The provider may bill for on-call and remote support when all of the following conditions are met:

• The activity was coordinated by the provider of CPS services;
• The participant does not receive Residential Habilitation services;
• The participant requires on-call or remote support for health & safety reasons;
• The provider informs the participant, & anyone identified by the participant, of what impact the on-call and remote support will have on the participant's privacy (if any). Effective communication must be provided, including use of any necessary auxiliary aids or services, to ensure that the participant can receive and convey information consistent with the requirements of the Americans with Disabilities Act. If there are impacts on the participants privacy, the provider must then obtain either the participant's consent in writing or the written consent of a legally responsible party for the participant. This process must be completed prior to the utilization of on-call & remote support; and
• Remote support is available immediately to the participant & on-call staff can be available for direct service within a maximum of 30 minutes (less if agreed upon by the service plan team).

Personal care assistance is included as a component of CPS but does not comprise the entirety of the service. The service also includes transportation as an integral component of the service; for example, transportation to a community activity. The CPS provider is not, however, responsible for transportation to & from a participant's home.

This service may be provided in the following settings:
• Community locations - Locations must be non-disability specific & meet all federal standards for home and community-based settings. When provided in community locations, this service cannot take place in licensed facilities, or any type of facility owned, leased or operated by a provider of other ODP services. Services are provided in a variety of integrated community locations that offer opportunities for the participant to achieve his or her personally identified goals for developing employment skills, community inclusion, involvement, exploration, and for developing & sustaining a network of positive natural supports. A maximum of 3 participants can be served simultaneously by any one provider at a community location at any one time.

• Community hubs - These settings primarily serve as a gathering place prior to & after community activities. Participants' time will be largely spent outside of the community hub, engaged in community activities. Community hubs should be non-disability specific, accessible, provide shelter in inclement weather, & be locations used by the general public. Community hubs could be locations that are focused on a specialty area of interest for participant(s) served (for example, employment interest area, volunteer site, related to arts, outdoors, music or sports).

A community hub could be a private home but is not the home of support staff. The participant's home may only serve as a hub on an occasional & incidental basis. The use of a community hub must be driven by the interest of the participant(s) served. A maximum of 6 participants can be served by any one provider at any one point in time in a community hub.

• Adult Training Facilities (subject to licensure under 55 Pa. Code Chapter 2380) - CPS may be provided in Adult Training Facilities which meet all federal standards for home and community-based settings.

• Older Adult Daily Living Centers (subject to licensure under 6 Pa. Code Chapter 11) - For participants 60 years or older, or participants with dementia or dementia-related conditions, CPS may be provided in Older Adult Daily Living Centers which meet all federal standards for home and community-based settings. Participants under 60 years of age receiving services in an Older Adult Daily Living Center prior to 7/1/17 may continue to receive services in these settings.

• Vocational Facilities (subject to licensure under 55 Pa. Code Chapter 2390) - CPS may be used to provide prevocational services in Vocational Facilities. Facilities must meet all federal standards for home and community-based settings. Facility-based prevocational services focus on the development of competitive worker traits through work as the primary training method. The service may be provided as:
o Occupational training used to teach skills for a specific occupation in the competitive labor market, and includes personal and work adjustment training designed to develop appropriate worker traits & teach understanding work environment expectations.

o Work related evaluation involving use of planned activities, systematic observation, & testing to formally assess the participant, including identification of service needs, potential for employment, & employment objectives.

This service may be used to provide prevocational services in facilities and community locations. All participants

receiving prevocational services must have a competitive integrated employment outcome included in their service plan. There must be documentation in the service plan regarding how and when the provision of prevocational services is expected to lead to competitive integrated employment.

Prevocational services in community locations or community hubs assist participants in vocational skill development, which means developing basic skills & competencies necessary for a participant to pursue competitive integrated employment. This includes the development & implementation of a preliminary plan for employment that identifies & addresses the participant's basic work interests, as well as skills & gaps in skills for his or her work interests. It may include situational assessments, which means spending time at an employer's place of business to explore vocational interests & develop vocational skills. Vocational skill development also includes identifying available transportation to help the participant get to and from work & teaching the participant & his or her family (as appropriate) about basic financial opportunities and benefits information for a move into competitive integrated employment.

More information about CPS requirements is located in the Additional Needed Information Section of the Main Module.

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

Handicapped employment as defined in Title 55, Chapter 2390 may not be funded through the Waiver.

A participant may be authorized for a maximum of 40 units of on-call and remote support per week. Only activities completed by direct service professionals as specified in the service definition are compensable as CPS services. The cost of purchasing devices, maintenance of the devices & service fees may not be billed under this service definition.

Participants may receive a maximum of 520 hours (2080 15-minute units) of direct service provided using remote technology per fiscal year.

Prevocational services may not be funded through the Waiver if they are available to participants through program funding under the IDEA. Documentation must be maintained in the participant's file to satisfy assurances that the service is not otherwise available through a program funded under the IDEA. Prevocational 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, prevocational services may only be authorized as a new service in the service plan when documentation has been obtained that OVR has closed the participant's case or that the participant has been determined ineligible for OVR services. Participants who are under the age of 25 may not receive prevocational services that pay subminimum wage unless they have been referred to OVR and OVR has closed the case or the participant has been determined ineligible for OVR services. Participants who are under the age of 25 are not required to be referred to OVR when they will be working on skill development and/or participating in activities for which they will not receive subminimum wage. It is not allowable, however, for these prevocational activities to occur in a licensed vocational facility unless OVR has closed their case or they have been determined ineligible for OVR services.

The following limits will be phased in regarding the amount of time a participant can receive CPS services in a licensed Adult Training Facility or a licensed Vocational Facility:

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

A variance may be granted, as determined by the service plan team if one of the following circumstances apply:

• The participant receives fewer than 12 hours (48 units) per week of CPS by the provider;
• The participant has current medical needs that limit the amount of time the person can safely spend in the community;
• The participant has an injury, illness, behaviors or change in mental health status that result in a risk to him or herself or others; or
• The participant declines the option to spend time in the community having been provided with opportunities to do so consistent with his or her preferences, choices and interests.

CPS services may not be provided at the same time as the direct provision of any of the following: Companion; In-Home And Community Supports; Small Group Employment; Job Finding or Development and Job Coaching and Support in Supported Employment; job acquisition and job retention in Advanced Supported Employment; Transportation; 15-minute unit Respite; Therapies; Education Support; Shift Nursing; Music, Art and Equine Assisted Therapy and Consultative Nutritional Services.

This service is generally provided between 8am to 5pm but is not restricted to those hours of the day. Alterations from typical day/work hours should be based on the participant's natural rhythms, preferred activities (not for convenience of a provider).

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

When CPS services are not provided with any other employment service (Small Group Employment, Supported Employment or Advanced Supported Employment) and the participant is not competitively employed, the hours of authorized CPS cannot exceed 40 hours (160 15-minute units) per participant per calendar week.

When the participant is competitively employed, the total number of hours for CPS, Supported Employment and/or Small Group Employment (whether utilized alone or in conjunction with one another) cannot exceed 50 hours (200 15-minute units) per participant per calendar week.

**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 | Prevocational Facility |
| Agency | Adult Training Facility or Older Adult Day Facility |
| Agency | Agency Community Participation Support Provider (Non- Facility) |
| Individual | Individual Community Participation Support Provider (Non-Facility) |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Community Participation Support**

**Provider Category:**

Agency

**Provider Type:**

Prevocational Facility

**Provider Qualifications**

**License** *(specify):*

Providers of facility-based prevocational services with a waiver service location in Pennsylvania must be licensed under 55 Pa. Code Chapter 2390 relating to Vocational Facilities. A comparable license is required for providers with waiver service locations in states contiguous to Pennsylvania.

At least one staff person (direct, contracted, or in a consulting capacity) who provides enhanced levels of service must be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) when the participant has been assessed to have medical needs that require a RN or LPN.

**Certificate** *(specify):*

Program specialists and supervisors of direct service professionals must have one of the following by 7/1/19 or within six months of hire if hired after 1/1/19:

• Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE), or

• Have been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.

All direct service professionals, program specialists, and supervisors of direct service professionals who provide Community Participation Support must complete the Department approved training on Community Participation Support by 7/1/18. After 7/1/18, all new hires must complete the Department approved training on Community Participation Support within 60 days of hire and during that time they must be supervised by someone who has completed the training.

Enhanced levels of service are based on the participant's behavioral or medical support needs. Effective 1/1/18, at least one staff person must have one of the following certifications or degrees to provide enhanced levels of service to participants who do not require a nurse to provide the enhanced level of service:

• NADD Competency Based Clinical Certification.

• NADD Competency-Based Dual Diagnosis Certification.

• NADD Competency-Based Direct-Support Professional Certification.

• Registered Behavior Technician.

• Certified Nursing Assistant.

• Board Certified Assistant Behavior Analyst.

• Bachelor’s Degree or higher in Psychology, Education, Special Education, Counseling, Social Work or Gerontology.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of Community Participation Support have automobile insurance

7. Have documentation that all vehicles used in the provision of Community Participation Support have current State motor vehicle registration and inspection.

8. Have Workers' Compensation Insurance in accordance with state law.

9. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Complete necessary pre/in-service training based on the service plan.

3. Have at least a 4 year degree when providing enhanced levels of Community Participation Support and the participant's assessed needs require the degree.

4. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5. Have child abuse clearance (when the participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6. Have a valid driver's license if the operation of a vehicle is necessary to provide Community Participation Support.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Community Participation Support**

**Provider Category:**

Agency

**Provider Type:**

Adult Training Facility or Older Adult Day Facility

**Provider Qualifications**

**License** *(specify):*

Providers of facility based day habilitation services with a waiver service location in Pennsylvania must be licensed under 55 Pa. Code Chapter 2380 relating to Adult Training Facilities or under 6 Pa. Code Chapter relating to Older Adult Day Services. A comparable license is required for providers with a waiver service location in states contiguous to Pennsylvania.

At least one staff person (direct, contracted, or in a consulting capacity) who provides enhanced levels of service must be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) when the participant has been assessed to have medical needs that require a RN or LPN.

**Certificate** *(specify):*

For programs providing prevocational training to participants, program specialists and supervisors of direct service professionals in facilities licensed under 55 Pa. Code Chapter 2380 must have one of the following by 7/1/19 or within six months of hire if hired after 1/1/19:
• Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE), or

• Have been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.

All direct service professionals, program specialists, and supervisors of direct service professionals who provide Community Participation Support must complete the Department approved training on Community Participation Support by 7/1/18. After 7/1/18, all new hires must complete the Department approved training on Community Participation Support within 60 days of hire and during that time they must be supervised by someone who has completed the training.

Enhanced levels of service are based on the participant's behavioral or medical support needs. Effective 1/1/18, at least one staff person must have one of the following certifications or degrees to provide enhanced levels of service to participants who do not require a nurse to provide the enhanced level of service:

• NADD Competency Based Clinical Certification.

• NADD Competency-Based Dual Diagnosis Certification.

• NADD Competency-Based Direct-Support Professional Certification.

• Registered Behavior Technician.

• Certified Nursing Assistant.

• Board Certified Assistant Behavior Analyst.

• Bachelor’s Degree or higher in Psychology, Education, Special Education, Counseling, Social Work or Gerontology.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of Community Participation Support have automobile insurance.

7. Have documentation that all vehicles used in the provision of Community Participation Support have current State motor vehicle registration and inspection.

8. Have Workers' Compensation Insurance in accordance with state law.

9. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

Adult Training Facility and Older Adult Day Facility staff working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Complete necessary pre/in-service training based on the service plan.

3. Have at least a 4 year degree when providing enhanced levels of Community Participation Support and the participant's assessed needs require the degree.

4. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5. Have child abuse clearance (when the participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6. Have a valid driver's license if the operation of a vehicle is necessary to provide Community Participation Support.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Community Participation Support**

**Provider Category:**

Agency

**Provider Type:**

Agency Community Participation Support Provider (Non- Facility)

**Provider Qualifications**

**License** *(specify):*

At least one staff person (direct, contracted, or in a consulting capacity) who provides enhanced levels of service must be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) when the participant has been assessed to have medical needs that require a RN or LPN.

**Certificate** *(specify):*

For programs providing prevocational training to participants, program specialists and supervisors of direct service professionals must have one of the following by 7/1/19 or within six months of hire if hired after 1/1/19:
• Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE), or

• Have been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.

All direct service professionals, program specialists, and supervisors of direct service professionals who provide Community Participation Support must complete the Department approved training on Community Participation Support by 7/1/18. After 7/1/18, all new hires must complete the Department approved training on Community Participation Support within 60 days of hire and during that time they must be supervised by someone who has completed the training.

Enhanced levels of service are based on the participant's behavioral or medical support needs. Effective 1/1/18, at least one staff person must have one of the following certifications or degrees to provide enhanced levels of service to participants who do not require a nurse to provide the enhanced level of service:

• NADD Competency Based Clinical Certification.

• NADD Competency-Based Dual Diagnosis Certification.

• NADD Competency-Based Direct-Support Professional Certification.

• Registered Behavior Technician.

• Certified Nursing Assistant.

• Board Certified Assistant Behavior Analyst.

• Bachelor’s Degree or higher in Psychology, Education, Special Education, Counseling, Social Work or Gerontology.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of Community Participation Support have automobile insurance.

7. Have documentation that all vehicles used in the provision of Advanced Supported Employment have current State motor vehicle registration and inspection.

8. Have Workers' Compensation Insurance in accordance with state law.

9. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Complete necessary pre/in-service training based on the service plan.

3. Have at least a 4 year degree when providing enhanced levels of Community Participation Support and the participant's assessed needs require the degree.

4. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5. Have child abuse clearance (when the participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6. Have a valid driver's license if the operation of a vehicle is necessary to provide Community Participation Support.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Community Participation Support**

**Provider Category:**

Individual

**Provider Type:**

Individual Community Participation Support Provider (Non-Facility)

**Provider Qualifications**

**License** *(specify):*

Individuals providing enhanced levels of Community Participation Support in community locations must be a licensed nurse (RN or LPN) when the participant's assessed medical needs require a licensed nurse provide the service.

**Certificate** *(specify):*

Individuals providing prevocational skill development to the participant in community locations must have one of the following by 7/1/19:
• Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE), or

• Have been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.

All individuals must complete the Department approved training on Community Participation Support by 7/1/18.

Enhanced levels of service are based on the participant's behavioral or medical support needs. Effective 1/1/18, individuals providing enhanced levels of service to participants who do not require a nurse to provide the enhanced level of service must have one of the following certificates or degrees:

• NADD Competency Based Clinical Certification.

• NADD Competency-Based Dual Diagnosis Certification.

• NADD Competency-Based Direct-Support Professional Certification.

• Registered Behavior Technician.

• Certified Nursing Assistant.

• Board Certified Assistant Behavior Analyst.

• Bachelor’s Degree or higher in Psychology, Education, Special Education, Counseling, Social Work or Gerontology.

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

Individuals must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of Community Participation Support have automobile insurance.

7. Have documentation that all vehicles used in the provision of Community Participation Support have current State motor vehicle registration and inspection.

8. Have Workers' Compensation Insurance in accordance with state law.

9. Have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

10. Be at least 18 years of age.

11. Have at least a 4 year degree when providing enhanced levels of Community Participation Support and the participant's assessed needs require the degree.

12. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

13. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

14. Have a valid driver's license if the operation of a vehicle is necessary to provide Community Participation Support.

15. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## 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:**

Education

**Alternate Service Title (if any):**

Education Support Services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
| --- | --- |
| 04 Day Services | 04030 education services |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Education Support consists of education and related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Act (IDEA) to the extent that they are not available under a program funded by IDEA or available for funding by the Office of Vocational Rehabilitation (OVR). To receive Education Support services through the waiver, students attending eligible institutions and who are eligible for Federal Student Aid and/or PA State Grant funding must apply. Education Support Services are limited to payment for the following:

• Tuition for adult education classes offered by a college, community college, technical school or university (institution of postsecondary education). This includes classes for which a participant receives credit, classes that a participant audits, classes that support paid or unpaid internships, remedial classes and comprehensive transition programs. At least 75% of the time the participant spends on campus must be integrated with the general student population.

• General fees charged to all students. This includes but is not limited to fees such as technology fees, student facilities fees, university services fees and lab fees.

• On campus peer support. This is support provided by the institution of postsecondary education's staff (they cannot be contracted staff) or other students attending the institution of postsecondary education. The support assists the participant to learn roles or tasks that are related to the campus environment such as homework assistance, interpersonal skills and residential hall independent living skills.

• Classes (one communication education professional and one participant or a group of no more than four learners taught collectively by a communication education professional) to teach participants who are deaf American Sign Language, Visual Gestural Communication or another form of communication. To receive this type of education, participants must be age 21 and older or under 21 years of age with a high school diploma. The participant must also have been assessed as benefitting from learning American Sign Language or another form of communication.

• Adult education or tutoring program for reading or math instruction.

Participants authorized for Education Support services must have an employment outcome or an outcome related to skill attainment or development which is documented in the service plan and is related to the Education Support need.

The following list includes items excluded as Education Support (please note this is not an exhaustive list of excluded items):

• Room and board.

• Payment for books.

• Payment for recreational classes, activities and programs offered through recreational commissions, townships, boroughs, etc.

• Tuition for adult education classes offered by online universities.

• Tuition for online classes.

• Tuition for adult education classes provided on disability specific campuses.

The provision of Education Support services may not be provided at the same time as the direct provision of any of the following: Community Participation Support; Small Group Employment; Supported Employment; job acquisition and job retention in Advanced Supported Employment; Benefits Counseling; Transportation; Therapies; Music, Art and Equine Assisted Therapy; Consultative Nutritional Services and 15-minute unit Respite. When on campus peer support is offered by the institution of postsecondary education and authorized in the service plan as Education Support, In-Home and Community Supports and Companion cannot be authorized at the same time as the on campus peer support.

This service can be delivered in Pennsylvania, Washington DC and Virginia as well as in states contiguous to Pennsylvania.

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

Participants can receive a maximum of:
• $35,000 toward tuition for classes in the participant's lifetime; and

• $5000 per semester of on campus peer support for participants taking at least 6 credit hours of classes per semester. On campus peer support cannot be reimbursed through Education Support when the participant takes fewer than 6 credit hours of classes per semester.

**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 | Institution of Postsecondary Education |
| Individual | Communication Education Professional |
| Agency | Communication Education Agency |
| Agency | Adult Education Program |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Education Support Services**

**Provider Category:**

Agency

**Provider Type:**

Institution of Postsecondary Education

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

The Institution of Postsecondary Education must meet the following standard:
1. Be an accredited postsecondary institution or program by the United States Department of Education.

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

Institution of Postsecondary Education must meet the following standards:
1. Have a waiver service location in Pennsylvania, Washington DC, Virginia or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Comply with Department standards related to provider qualifications.

Staff providing on campus peer support as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS, VF/EA FMS, OHCDS, ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Education Support Services**

**Provider Category:**

Individual

**Provider Type:**

Communication Education Professional

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

To teach communication to participants who are deaf, the communication education professional must have the following Certificates:
1. Have, at a minimum, Qualified Level Certification from the American Sign Language Teachers Association (ASLTA).

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

To teach communication to participants who are deaf, the communication education professional must meet the following standards:
1. Be at least 18 years of age.

2. Have a waiver service location in Pennsylvania, Washington DC, Virginia or a state contiguous to Pennsylvania.

3. Have a signed ODP Provider Agreement on file with ODP.

4. Complete standard ODP required orientation and training.

5. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

6. Have at least Advanced or higher Sign Language Skills as determined by the Sign Language Proficiency Interview (SLPI).

7. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

8. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

9. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS, VF/EA FMS, OHCDS, ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Education Support Services**

**Provider Category:**

Agency

**Provider Type:**

Communication Education Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

To teach communication to participants who are deaf, the Communication Education Professionals working for or contracted with the agency must have, at a minimum:
1. Qualified Level Certification from the American Sign Language Teachers Association (ASLTA).

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

To teach communication to participants who are deaf, the Communication Education Agency must meet the following standards:
1. Have a waiver service location in Pennsylvania, Washington DC, Virginia or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Comply with Department standards related to provider qualifications.

Communication Education Professionals working for or contracted with the agency as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Have at least Advanced or higher Sign Language Skills as determined by the Sign Language Proficiency Interview (SLPI).

3. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

4. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS, VF/EA FMS, OHCDS, ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Education Support Services**

**Provider Category:**

Agency

**Provider Type:**

Adult Education Program

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

To provide adult education or tutoring for reading or math instruction the agency must meet the following standards:
1. Have a waiver service location in Pennsylvania, Washington DC, Virginia or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Have at least one staff person with a four year degree and state teaching credentials.

4. Comply with Department standards related to provider qualifications.

Staff working for or contracted with the adult education program as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS, VF/EA FMS, OHCDS, ODP or its Designee

**Frequency of Verification:**

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

## 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):**

Family Medical Support Assistance

**HCBS Taxonomy:**

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

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

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

**Service Definition** *(Scope):*

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

The Family Medical Support Assistance service assists with coordination of services related to the participant's medically complex condition in the participant's home. This is a direct and indirect service that does not involve direct care. Providers are required to render the following two components of the service.

1. Family support assistant - The family support assistant provides assistance to participants and their families with coordination of unpaid supports and waiver services such as skilled nursing services, home health services, medical services, and behavioral health services in the participant's home including:

- Scheduling medical and behavioral health appointments and assisting with medical visits (both in office and via remote technology);
- Understanding the concerns of the participant, family and other designated persons about medical providers or services and assisting with mitigating those concerns when possible;
- Directly assisting the participant, family and other designated person(s) with the discharge process from a hospital, clinic, or nursing home setting with going home. The discharge process may include accompanying the family and other designated person(s) when bringing the participant home if transportation is an issue, assisting with obtaining discharge information and educating the family, other designated person(s) and the participant on the discharge information, and ensuring that the participant's home is set up for home care and treatment based on the participant's needs;
- Facilitating access to generic community services;
- Assisting with communication with insurance providers to facilitate understanding of coverage and coordination of needed medical services;
- Assisting in obtaining needed medication, supplies, and equipment;
- Identifying barriers that prevent participants from accessing effective and necessary medical services and supports and collaborate with ISP team members regarding possible ways to reduce those barriers;
- Assisting with implementation of the service plan and life course plan with the family;
- Providing training and consultative assistance on implementation of non-medical aspects of the ISP to the family or Children Youth and Family supervised family and team members; and
- Training staff supports coming into the home on non-medical aspects of the ISP and roles and responsibilities of team members of implementation of non-medical aspects of the ISP.

2. Nursing Oversight – Nursing oversight is completed by a licensed nurse within the scope of the state's Nurse Practice Act and includes the following:

- Assessment of the participant's medically complex condition;
- Completion of Health Risk Screening Tool Clinical Reviews in accordance with ODP protocols;
- Identification of training needs related to the participant's medically complex condition and providing training to the participant, unpaid caregivers, and paid professionals;
- Training and consultative assistance on implementation of medical aspects of the service plan to the family or Children Youth and Families supervised family and team members;
- Training staff supports coming into the home on medical aspects of the service plan and roles and responsibilities of team members of implementation of medical aspects of the service plan;
- Helping the participant, family and any other designated persons or waiver service providers understand the participant's medically complex condition and impact on the participant's behavioral or emotional health;
- Consulting with doctors and other healthcare professionals; and
- Supervision and evaluation of the participant's medical and/or behavioral health needs or anything that maintains the participant's best state of health.

Nursing oversight differs from nursing available for children under the State Plan in the nature of the services provided and provider type. State Plan services provide only for direct nursing services while nursing oversight allows a nurse to train and supervise family or service providers and monitor their provision of these services.

The family support assistant and nurse work as a team to support each participant, family and other supporters and service providers. The family support assistant and nurse will communicate with the Supports Coordinator on a regular basis to ensure that the service plan is up-to-date and that the Supports Coordinator is aware of any needed coordination, location, and/or monitoring of supports and services that fall under the scope of the Supports Coordination service. The family support assistant may provide Family Medical Support Assistance to no more than 8 participants for this or any other service. A licensed nurse may provide Family Medical Support Assistance to no more than 16 participants for this or any other service.

Completion of the Health Risk Screening Tool and adherence to Health Risk Screening Tool protocols is required as

part of the Family Medical Support Assistance service.

Family Medical Support Assistance is available to participants who live in private homes. This service is not available to participants who receive Life Sharing, Supported Living or Residential Habilitation services.

Relatives who do not live with the participant or are not responsible for direct care of the participant may render this service.

**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 |
|---|---|
| Agency | Family Medical Support Assistance Agency |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Family Medical Support Assistance**

**Provider Category:**

Agency

**Provider Type:**

Family Medical Support Assistance Agency

**Provider Qualifications**

**License** *(specify):*

Staff (direct, contracted, or in a consulting capacity) providing the nursing oversight component must be a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

Providers must comply with 49 Pa. Code Chapter 21.

**Certificate** *(specify):*

Family support assistants must meet one of the following sets of requirements:
1. A master's degree or above from an accredited college or university and 1 year work experience working directly with persons with an intellectual disability, developmental disability, and/or autism.
2. A bachelor's degree from an accredited college or university and 2 years work experience working directly with persons with an intellectual disability, developmental disability, and/or autism.
3. An associate's degree or 60 credit hours from an accredited college or university and 4 years work experience working directly with persons with an intellectual disability, developmental disability, and/or autism.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania.
2. Have a signed ODP Provider Agreement on file with ODP.
3. Complete standard ODP required orientation and training.
4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.
5. Have Commercial General Liability Insurance.
6. Have Workers' Compensation Insurance, in accordance with state law.
7. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant to carry out the service plan which includes but is not limited to medical, communication, mobility and behavioral needs.
8. Comply with Department standards related to provider qualifications.

Staff must meet the following standards:
1. Be at least 18 years of age.
2. Complete necessary pre/in-service training based on the service plan.
3. Have a Pennsylvania State Police criminal history record check prior to the date of hire. If the prospective employee is not a resident of the Commonwealth of Pennsylvania or has not been a resident of the Commonwealth of Pennsylvania for at least two years prior to the date of employment, a Federal Bureau of Investigation criminal history record check must be obtained prior to the date of hire. If a criminal history clearance and/or the criminal history record check identifies a criminal record, providers must make a case-by-case decision about whether to hire the person that includes consideration of the following factors:
a. The nature of the crime;
b. Facts surrounding the conviction;
c. Time elapsed since the conviction;
d. The evidence of the individual's rehabilitation; and
e. The nature and requirements of the job.
Documentation of the review must be maintained for any staff that were hired whose criminal history clearance results or criminal history check identified a criminal record.
4. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

# Appendix C: Participant Services

## C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Homemaker

**Alternate Service Title (if any):**

Homemaker/Chore

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08050 homemaker |
| **Category 2:** | **Sub-Category 2:** |
| 08 Home-Based Services | 08060 chore |
| **Category 3:** | **Sub-Category 3:** |
| | |

**Service Definition** *(Scope):*

| Category 4: | Sub-Category 4: |
|---|---|
| | |

Homemaker/Chore services are provided to participants who live in private homes.

HOMEMAKER

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Homemaker services enable the participant or the family member(s) or friend(s) with whom the participant resides to maintain their primary private home. Homemaker Services include cleaning and laundry, meal preparation, and other general household care. Homemaker services also include infection control measures and intensive cleaning for participants whose medically complex condition requires this level of service. Infection control and intensive cleaning can include cleaning medical equipment, disinfecting the home, etc.

CHORE

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Chore services consist of services needed to maintain the home in a clean, sanitary, and safe condition. Chore services consist of heavy household activities such as washing floors, windows, and walls; tacking down loose rugs and tiles; moving heavy items of furniture in order to provide safe access and egress; ice, snow, and/or leaf removal; and yard maintenance. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Maintenance in the form of upkeep and improvements to the participant's home is excluded from federal financial participation.

Homemaker/Chore services can only be provided in the following situations when there is no other relative, caregiver, landlord, community/volunteer agency, provider agency staff, or third-party payer that is capable of or responsible for the provision:

1. When a participant and household members are temporarily unable to perform Homemaker/Chore functions covered under the service definition. Examples include:

- If a participant has a temporary medical need due to a hospitalization or from a surgery, and as a result, the caregiver does not have time to perform the Homemaker/Chore functions due to the increased care needs of the participant.
- If the caregiver who usually performs the Homemaker/Chore functions has a temporary medical condition that renders them unable perform the Homemaker/Chore functions. There is no one else that is capable of or responsible for the provision of the Homemaker/Chore functions.
- The household member who usually performs the Homemaker/Chore functions is temporarily absent and there is no one else that is capable of or responsible for the provision of the Homemaker/Chore functions.

2. When a participant or household member is permanently unable to perform the Homemaker/Chore functions. Examples include:

- The participant has a medical need or disability that requires constant direct care which results in the caregiver not having time on a routine basis to perform Homemaker/Chore functions.
- The caregiver has more than 1 child and Homemaker/Chore services would enable the caregiver to spend more time providing care to the child participant who has a medical need or disability.

The service plan team is responsible for determining whether a person is temporarily or permanently unable to perform the Homemaker/Chore functions. The service plan team's determination must be documented in the service plan.

Participants authorized to receive Homemaker/Chore services may not be authorized to receive the following services as Homemaker/Chore tasks are built into the rates for these services: Residential Habilitation Services, Life Sharing or Supported Living.

This service must be delivered in Pennsylvania.

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

Homemaker/Chore services are limited to 40 hours per participant per fiscal year when the participant or family member(s) or unpaid caregiver(s) with whom the participant resides is temporarily unable to perform the homemaker/chore functions. A person is considered temporarily unable when the condition or situation that prevents him or her from performing the homemaker/chore functions is expected to improve. There is no limit when the participant lives independently or with family members or unpaid caregivers who are permanently unable to perform the homemaker/chore functions.

A person is considered permanently unable when the condition or situation that prevents them from performing the homemaker/chore functions is not expected to improve. The service plan team is responsible to determine whether a person is temporarily or permanently unable to perform the homemaker/chore functions. The service plan team's determination should be documented in the service plan.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Homemaker/Chore Agency |
| Individual | Support Service Professional |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Homemaker/Chore**

**Provider Category:**

Agency

**Provider Type:**

Homemaker/Chore Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance, in accordance with state law.

7. Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS, VF/EA FMS, ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Homemaker/Chore**

**Provider Category:**

Individual

**Provider Type:**

Support Service Professional

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

The Support Service Professional must meet the following standards:
1. Be at least 18 years of age.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

4. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS or VF/EA FMS

**Frequency of Verification:**

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

## 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:**

Habilitation

**Alternate Service Title (if any):**

In-Home and Community Support

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08010 home-based habilitation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |

**Service Definition** (Scope):

In-Home and Community Support is a direct service provided in home & community settings to assist participants in acquiring, maintaining & improving the skills necessary to live in the community, to live more independently, & to participate meaningfully in community life. Direct In-Home and Community Support services may be provided using remote technology in accordance with ODP policy. To the extent that In-Home and Community Support is provided in community settings, the settings must be inclusive rather than segregated.

Services consist of assistance, support & guidance (physical assistance, instruction, prompting, modeling, and positive reinforcement) in the general areas of self-care, health maintenance, decision making, home management, managing personal resources, communication, mobility and transportation, relationship development & socialization, personal adjustment, participating in community functions, activities & use of community resources. The type & amount of assistance, support & guidance are informed by the assessed need for physical, psychological & emotional assistance established through the assessment & person-centered planning processes & is to enhance the autonomy of the participant, in line with his or her personal preferences & to achieve their desired outcomes.

The In-Home and Community Support provider must provide the level of services necessary to enable the participant to meet habilitation outcomes. This includes ensuring the following assistance, support & guidance (prompting, instruction, modeling, positive reinforcement) will be provided to the participant as needed to:
1. Carry out activities of daily living such as personal grooming & hygiene, dressing, making meals, maintaining a clean environment.
2. Learn & develop practices that promote good health and wellness such as nutritious meal planning, regular exercise, carrying through prescribed therapies exercises, awareness & avoidance of risk including environmental risks, exploitation & abuse; responding to emergencies in the home & community such as fire or injury; knowing how & when to seek assistance.
3. Manage their medical care including scheduling & attending medical appointments, filling prescriptions & self-administration of medications, & keeping health logs & records. This may also include assistance, support & guidance in the administration of medications in accordance with applicable regulatory guidance, positioning the participant, taking vital statistics, performing range of motion exercises as directed by a licensed professional, applying prescribed treatments & monitoring for seizure activity.
4. Manage their mental health diagnosis & emotional wellness including self-management of emotions such as disappointment, frustration, anxiety, anger, & depression; applying trauma informed care principles & practices; & accessing mental health services. This includes implementation of the Behavior Support component of the plan, the Crisis Intervention component of the plan &/or the Skill Building component of the plan which may involve collecting and recording the data necessary to evaluate progress and the need for revisions to the plan.
5. Participate in the development & implementation of the service plan & to direct the person-centered planning process including identifying who should attend & what the desired outcomes are.
6. Manage their home including locating a private home, arranging for utility services, paying bills, routine home maintenance, & home safety.
7. Achieve financial stability through activities such as managing personal resources, general banking & balancing accounts, record keeping & managing savings accounts & utilizing programs such as ABLE accounts.
8. Communicate with providers, caregivers, family members, friends & others face-to-face & through the use of the telephone, correspondence, the internet, & social media. The service may require knowledge & use of sign language or interpretation for individuals whose primary language is not English.
9. Develop & maintain relationships with members of the broader community (examples include: neighbors, coworkers, friends & family) & to manage problematic relationships.
10. Exercise rights as a citizen and fulfill their civic responsibilities such as voting & serving on juries; attending public community meetings; to participate in community projects & events with volunteer associations & groups; to serve on public and private boards, advisory groups, & commissions, as well as develop confidence & skills to enhance their contributions to the community.
11. Participate in preferred activities of community life such as shopping, going to restaurants, museums, movies, concerts, dances & faith based services.
12. Make decisions including providing guidance in identifying options/choices & evaluating those against a set of personal preferences and desired outcomes. This includes assistance with identifying supports available within the community.
13. Use a range of transportation options including buses, trains, cab services, driving, joining car pools, etc.
14. Develop their personal interests such as hobbies, appreciation of music, & other experiences the participant enjoys or may wish to discover.
15. Identification of risk to the participant & the implementation of actions such as reporting incidents as required by ODP, the Older Adults Protective Services Act, the Adult Protective Services Act and the Child Protective Service

Law, applicable regulations &/or calling emergency officials for immediate assistance.
16. Successfully parent their child(ren). This includes assessing parenting competency, modeling & teaching parenting skills such as discipline techniques, child development, health & safety issues & decision-making skills.

In-Home and Community Support may also include elements of Companion services as long as these elements do not constitute more than half of the In-Home and Community Support service.

Staff providing the In-Home and Community Support must be awake during overnight hours for the purpose of performing tasks that require continual in-person assistance as identified in the service plan to ensure medical or behavioral stability & that are able to be performed by a trained non-medically-licensed individual. These tasks include:
• Taking vital statistics when monitoring has been prescribed by a licensed professional, such as post-surgical care,
• Positioning,
• Performing range of motion exercises as directed by a licensed professional,
• Administering prescribed medications (other than over the counter medications),
• Applying prescribed treatments,
• Monitoring for seizure activity for a participant with convulsive (grand mal) epilepsy that is not able to be controlled by medication,
• Maintaining the functioning of devices whose malfunction would put the participant at risk of hospitalization, &
• Crisis intervention in accordance with the participant's behavior support plan.

Remote technology cannot be used to provide overnight or enhanced levels of In-Home and Community Support because direct in-person assistance is required. If the participant only needs supervision or assistance with tasks that do not meet the criteria above such as evacuation in the event of an emergency during overnight hours, the appropriate service during this time period is Companion services.

This service may be provided at the following levels:
• Basic – Staff-to-individual ratio of 1:3
• Level 1 – Staff to individual ratio of 1:2
• Level 2 - Staff-to-individual ratio of 1:1
• Level 2 Enhanced - Staff-to-individual ratio of 1:1 with a staff member who is certified, has a bachelor's degree or is a nurse. Level 2 Enhanced services by a nurse are only available to participants age 21 & older
• Level 3 - Staff-to-individual ratio of 2:1
• Level 3 Enhanced - Staff-to-individual ratio of 2:1 with 1 staff member who is certified, has a bachelor's degree or is a nurse & 1 staff member with at least a high school diploma. Level 3 Enhanced services by a nurse are only available to participants age 21 & older

The use of Level 2 Enhanced, Level 3 and Level 3 Enhanced are based on the participant’s behavioral or medical support needs. The need for enhanced levels of service must be reviewed every 6 months in accordance with ODP policy for continued authorization.

Transportation necessary to enable participation in community activities outside of the home accordance with the participant’s service plan is included in the rate paid to agency providers. Mileage that is needed to enable participation in community activities that exceeds 30 miles on any given day should be authorized on the service plan & billed by the agency as Transportation Mile. Transportation is not included in the wage range for In-Home and Community Support services provided by Support Service Professionals in participant directed services. Transportation services should be authorized & billed as a discrete service. When Transportation services are authorized and billed as a discrete service (regardless of whether the services are delivered by an agency or Support Service Professional) In-Home and Community Support is compensable at the same time for the supervision, assistance &/or care provided to the participant during transportation. In-Home and Community Support services cannot be used to solely transport a participant as this would be considered a Transportation service available in the waiver. The participant must have a need for assistance, guidance or support with tasks while in the home and community locations for which transportation is necessary.

In general, this service is provided in a participant’s private home, other community settings, or in a hospital when the participant is hospitalized. This service shall not be provided in a licensed setting, unlicensed residential setting or camp. This does not preclude this service from being utilized to assist a participant to volunteer in a nursing facility or hospital or occasionally visit a friend or family member in a licensed setting or unlicensed residential

setting.

In-Home and Community Support services may be delivered in a hospital, in accordance with Section 1902(h) of the Social Security Act, when the services are:
• Identified in the participant's service plan;
• Provided to meet needs of the participant that are not met through the provision of hospital services;
• Designed to ensure smooth transitions between the hospital & home & community-based settings, and to preserve the participant's functional abilities; &
• Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or state law, or under another applicable requirement.

This service can only be provided in a hospital setting to assist the participant with 1 or more of the following:
• Communication;
• Intensive personal care; or
• Behavioral support/stabilization as enumerated in the behavior support plan.

When In-Home and Community Support is provided to a participant who is younger than 18 years of age, this service may only be used to provide extraordinary care. Relatives & legally responsible individuals are responsible to meet the needs of a participant who is younger than 18 years of age, including the need for assistance & supervision typically required for children at various stages of growth & development. In-Home and Community Support may only be used to meet the exceptional needs of the participant who is under age 18 that are due to their disability & are above & beyond the typical, basic care for a child that all families with children may experience.

This service can be delivered in Pennsylvania (PA) & in states contiguous to PA. During temporary travel, this service may be provided in PA or other locations as per the ODP travel policy.

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

In-Home and Community Support services that are authorized on a service plan may be provided by relatives and legal guardians of the participant. When this occurs, any one relative or legal guardian may provide a maximum of 40 hours per week of authorized In-Home and Community Support or a combination of In-Home and Community Support and Companion (when both services are authorized in the service plan). Further, when multiple relatives/legal guardians provide the service(s) each participant may receive no more than 60 hours per week of authorized In-Home and Community Support or a combination of In-Home and Community Support and Companion (when both services are authorized in the service plan) from all relatives/legal guardians. An exception may be made to the limitation on the number of hours of In-Home and Community Support and Companion provided by relatives and legal guardians at the discretion of the employer if there is an emergency or an unplanned departure of a regularly scheduled worker for up to 90 calendar days in any fiscal year.

Effective starting 7/1/17, In-Home and Community Support services may not be provided at the same time as the direct provision of any of the following: Respite (15-minute and Day); Companion; Community Participation Support; Small Group Employment; Supported Employment; job acquisition and job retention in Advanced Supported Employment and Shift Nursing.

To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

**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 | Agency |
| Individual | Support Service Professional |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: In-Home and Community Support**

**Provider Category:**

Agency

**Provider Type:**

Agency

**Provider Qualifications**

**License** *(specify):*

At least one staff person (direct, contracted, or in a consulting capacity) who provides Level 2 enhanced or Level 3 enhanced services to a participant age 21 or older must be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) when the participant has been assessed to have medical needs that require a RN or LPN as well as other needs for assistance, support and guidance to meet habilitative outcomes that will be provided by the RN or LPN.

**Certificate** *(specify):*

Enhanced levels of service are based on the participant's behavioral or medical support needs. Effective 1/1/18, at least one staff person must have one of the following certifications or degrees to provide Level 2 enhanced or Level 3 enhanced services to participants who do not require a nurse to provide the enhanced level of service:

• NADD Competency Based Clinical Certification.

• NADD Competency-Based Dual Diagnosis Certification.

• NADD Competency-Based Direct-Support Professional Certification.

• Registered Behavior Technician.

• Certified Nursing Assistant.

• Board Certified Assistant Behavior Analyst.

• Bachelor’s Degree or higher in Psychology, Education, Special Education, Counseling, Social Work or Gerontology.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania, Washington DC, Virginia or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of In-Home and Community Support have automobile insurance.

7. Have documentation that all vehicles used in the provision of In-Home and Community Support have current State motor vehicle registration and inspection.

8. Have Workers' Compensation Insurance, in accordance with state law.

9. Have an annual training plan to improve the knowledge, skills and core competencies of agency personnel.

10. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant to carry out the service plan which includes but is not limited to communication, mobility and behavioral needs.

11. Comply with Department standards related to provider qualifications.

Staff working for or contracted with the agency as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Complete necessary pre/in-service training based on the service plan.

3. Have at least a high school diploma for participants authorized to receive 2:1 enhanced In-Home and Community Support. The other staff member must have a certification or be a nurse.

4. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

6. Have a valid driver's license if the operation of a vehicle is necessary to provide In-Home and Community Support services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

# Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: In-Home and Community Support**

**Provider Category:**

Individual

**Provider Type:**

Support Service Professional

**Provider Qualifications**

**License** *(specify):*

Support Service Professionals who provide Level 2 enhanced or Level 3 enhanced services to a participant age 21 or older must be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) when the participant has been assessed to have medical needs that require a RN or LPN as well as other needs for assistance, support and guidance to meet habilitative outcomes that will be provided by the RN or LPN.

**Certificate** *(specify):*

Enhanced levels of service are based on the participant's behavioral or medical support needs. Effective 1/1/18, the Support Service Professional must have one of the following certifications or degrees to provide Level 2 enhanced or Level 3 enhanced services to participants who do not require a nurse to provide the enhanced level of service:

- NADD Competency-Based Clinical Certification.
- NADD Competency-Based Dual Diagnosis Certification.
- NADD Competency-Based Direct-Support Professional Certification.
- Registered Behavior Technician.
- Certified Nursing Assistant.
- Board Certified Assistant Behavior Analyst.
- Bachelor’s Degree or higher in Psychology, Education, Special Education, Counseling, Social Work or Gerontology.

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

Support Service Professionals must meet the following standards:
1. Be at least 18 years of age.

2. Have documentation that all vehicles used in the provision of In-Home and Community Support have automobile insurance.

3. Have documentation that all vehicles used in the provision of In-Home and Community Support have current State motor vehicle registration and inspection.

4. Complete necessary pre/in-service training based on the service plan.

5. Be trained to meet the needs of the participant to carry out the service plan which includes, but is not limited to, communication, mobility and behavioral needs.

6. Have at least a high school diploma for participants authorized to receive 2:1 enhanced In-Home and Community Support. The other staff member must have a certification or be a nurse.

7. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

8. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

9. Have a valid driver's license if the operation of a vehicle is necessary to provide In-Home and Community Support services.

10. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS or VF/EA FMS

**Frequency of Verification:**

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

## 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:** |
| | |

**Service Definition** *(Scope):*

| Category 4: | Sub-Category 4: |
| --- | --- |
| | |

Respite services are direct services that are provided to supervise and support participants living in private homes on a short-term basis for planned or emergency situations, giving the person(s) normally providing care a period of relief that may be scheduled or due to an emergency. Respite services do not cover the care provided to a minor child when the primary caregiver or legally responsible individual is absent due to work.

In emergency situations, Respite services may be provided in a home licensed under 55 Pa. Code Chapters 6400, 6500, 3800 or 5310 beyond the home's approved program capacity (but not beyond the home's licensed capacity) or in a non-waiver funded licensed residential setting or in a hotel when approved by ODP. Settings considered non-waiver funded licensed residential settings include residential settings located on a campus or that are contiguous to other ODP-funded residential settings (settings that share one common party wall are not considered contiguous). This also includes settings enrolled on or after the effective date of the Chapter 6100 regulations that are located in any development or building where more than 25% of the apartments, condominiums or townhouses have waiver funded Residential Habilitation, Life Sharing or Supported Living being provided.

An emergency circumstance is defined as a situation where:

- A participant's health and welfare is at immediate risk;

- A participant experiences the sudden loss of his or her home (due to, for example, a fire or natural disaster). This is not intended to replace a residential provider's responsibility to secure an alternative if there is a need for an emergency location;

- A participant loses the care of a relative or unrelated caregiver, without advance warning or planning; or

- There is an imminent risk of institutionalization.

*

To the degree possible, the respite provider must maintain the participant's schedule of activities including activities that allow participation in the community. This service also includes implementation of a participant's Behavioral Support Plan, Medical Plan, or Crisis Intervention Plan as applicable.

Respite services may only be provided in the following location(s):

- Participant's private home located in Pennsylvania.

- Licensed Family Living Home (55 Pa. Code Chapter 6500) located in Pennsylvania.

- Licensed Community Home (55 Pa. Code Chapter 6400) located in Pennsylvania within the home's approved program capacity of 1 to 4. ODP may approve the provision of Respite services above a home's approved program capacity or in a home with approved program capacity of 5 to 8 for emergency circumstances or to meet medical or behavioral needs as described in the paragraph below.

- Licensed Child Residential Service Home (55 Pa. Code Chapter 3800) located in Pennsylvania.

- Licensed Community Residential Rehabilitation Services for the Mentally Ill Home (55 Pa. Code Chapter 5310) located in Pennsylvania.

- Unlicensed Life Sharing home that is located in Pennsylvania.

- Unlicensed private home that is located in Pennsylvania, Washington DC, or Virginia or a state contiguous to Pennsylvania.

- Other private homes, hotels, or rentals during temporary travel in accordance with ODP's travel policy.

- Camp settings that meet applicable state or local codes.

- Community settings that maintain the participant's schedule of activities.

A variance for Respite services in the following settings may be requested when the participant has a Needs Group 3 or 4 that indicates medical or behavioral needs and the participant is unable to locate a respite provider to render services in a community setting:

• Licensed Intermediate Care Facilities for individuals with an Intellectual Disability (55 Pa. Code 6600) that are owned and operated by private agencies.

• Licensed Nursing Homes (28 Pa. Code Chapters 201, 203, 205, 207, 209 and 211).

• Licensed Community Home (55 Pa. Code Chapter 6400) located in Pennsylvania within the home's approved program capacity of 5 to 8.

When Respite is provided in a Residential Habilitation or Life Sharing setting, the setting must be integrated and dispersed in the community in noncontiguous locations, and may not be located on campus settings. Exceptions to these criteria can be requested in accordance with ODP policy.

Respite services may not be provided in Hospitals, Personal Care Homes or public ICFs/ID (ICFs/ID that are owned and operated by any state).

This service may be provided at the following levels in private homes including Life Sharing homes (licensed or unlicensed):

• Basic - Staff-to-individual ratio of 1:4. (This level does not apply to Respite provided in a Life Sharing home.)

• Level 1 - Staff-to-individual ratio range of 1:3. (This level does not apply to Respite provided in a Life Sharing home.)

• Level 2 - Staff-to-individual ratio range of 1:2.

• Level 3 - Staff-to-individual ratio of 1:1.

• Level 3 Enhanced - Staff-to-individual ratio of 1:1 with a licensed nurse (only available to children with medical needs as described below) or a certified staff member.

• Level 4 - Staff-to-individual ratio of 2:1.

• Level 4 Enhanced - Staff-to-individual ratio of 2:1 with one licensed nurse (only available to children with medical needs as described below) or one certified staff member and one staff member with at least a high school diploma.

The use of Level 3 Enhanced, Level 4 and Level 4 Enhanced are based on the participant’s behavioral or medical support needs. Only children who have a medically complex condition can receive Respite by a nurse. Any waiver participant age 21 or older who needs nursing services can receive this type of support through the Shift Nursing service.

This service may be provided at the following levels in Residential Habilitation settings:

• Needs Group 1.

• Needs Group 2.

• Needs Group 3.

• Needs Group 4.

Participants can receive two categories of Respite services in private homes (excluding Life Sharing provided in private homes): Day respite and 15-minute respite. Day respite in private homes must be provided for periods of more than 16 hours, and is billed using a daily unit. 15-minute respite in private homes is provided for periods of 16 hours or less, and is billed using a 15-minute unit.

Participants may not be authorized for 15-minute unit respite provided in Residential Habilitation settings, Life Sharing settings, private ICFs/ID and licensed nursing homes. Day respite is the only type of Respite allowable to be provided in these settings. Day respite authorized in these settings must be provided for periods of more than 8 hours.

Room and board costs are included in the fee schedule rate solely for Respite provided in a licensed residential setting. For this reason, there may not be a charge for room and board to the participant for Respite that is provided in a licensed residential setting. There may not be a charge to the participant for room and board in camp settings that are licensed or accredited. The waiver will reimburse the room and board fee charged to the general public if the camp is licensed or accredited. The camp should provide separate documentation of the service cost and the room and board component based on the accreditation or certification standard for the camp.

Participants authorized to receive 15-minute unit Respite services may not receive the direct portion of the following services at the same time: Community Participation Support; Small Group Employment; Supported Employment; Advanced Supported Employment; Education Support; Music, Art and Equine Assisted Therapy and Consultative Nutritional Services.

Participants authorized to receive Respite services (15-minute or Day) may not receive the following services at the same time: Companion, In-Home and Community Supports, and Shift Nursing.

Room and board costs are included in the fee schedule rate solely for Respite provided in a licensed residential setting. For this reason, there may not be a charge for room and board to the participant for Respite that is provided in a licensed residential setting. There may not be a charge to the participant for room and board in camp settings that are licensed or accredited. The waiver will reimburse the room and board fee charged to the general public if the camp is licensed or accredited. The camp should provide separate documentation of the service cost and the room and board component based on the accreditation or certification standard for the camp.

Participants authorized to receive 15-minute unit Respite services may not receive the direct portion of the following services at the same time: Community Participation Support; Small Group Employment; Supported Employment; Advanced Supported Employment; Education Support; Music, Art and Equine Assisted Therapy and Consultative Nutritional Services.

Participants authorized to receive Respite services (15-minute or Day) may not receive the following services at the same time: Companion, In-Home and Community Supports, and Shift Nursing.

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

Respite services are limited to:
- 30 units of day respite per participant without a medically complex condition in a period of one fiscal year,
- 45 units of day respite per participant with a medically complex condition in a period of one fiscal year, and
- 480 units (Consolidated Waiver) or 1440 units (Community Living and P/FDS Waivers) of 15-minute unit respite per participant in a period of one fiscal year.

Requests for a variance to this limit may be made for participants who have behavioral or medical support needs or for emergency circumstances using the standard ODP variance process. Ongoing nursing needs for children with medical needs are addressed through Medical Assistance Fee-for-Service or Physical Health Managed Care Organizations.

**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 | Agency |

| Provider Category | Provider Type Title |
|---|---|
| Individual | Support Service Professional |
| Agency | Respite Camp Agency |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Agency

**Provider Qualifications**

**License** *(specify):*

When Respite is provided in a residential or facility setting in Pennsylvania, proof of the following licensure must be provided when applicable:

• 55 Pa. Code Chapter 6400 when Respite is provided in Community Homes for people with intellectual disabilities;

• 55 Pa. Code Chapter 6500 when Respite is provided in Family Living Homes;

• 55 Pa. Code Chapter 3800 when Respite is provided in child residential homes;

• 55 Pa. Code Chapter 5310 when Respite is provided in licensed Community Residential Rehabilitation Services for the Mentally Ill Home;

• Licensed Intermediate Care Facilities for individuals with an Intellectual Disability (55 Pa. Code 6600) that are owned and operated by private agencies; or

• Licensed Nursing Homes (28 Pa. Code Chapters 201, 203, 205, 207, 209 and 211).

For children (under age 21) with a medically complex condition who require Respite by a nurse, at least one staff person (direct, contracted, or in a consulting capacity) who provides enhanced levels of service must be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) when the participant has been assessed to have medical needs that require a RN or LPN.

• There must be documentation showing that the RN or LPN has previous experience with serving children or adults with a medically complex condition; and

• There must be documentation that the RN or LPN has responsibility for training staff on the participant's medical care and related plans, assessing the participant's health status and is available for consultation 16 hours daily. The documentation of the RN or LPN responsibilities may be included within the agency's policy, protocol, or job description.

**Certificate** *(specify):*

Enhanced levels of service are based on the participant's behavioral or medical support needs. Effective 1/1/18, at least one staff (direct, contracted, or in a consulting capacity) providing enhanced levels of Respite must have one of the following professional credentials or degrees:

- NADD Competency-Based Clinical Certification;
- NADD Competency-Based Dual Diagnosis Certification;
- NADD Competency-Based Direct-Support Professional Certification;
- Registered Behavior Technician;
- Certified Nursing Assistant;
- Board Certified Assistant Behavior Analyst; or
- Bachelor’s Degree or higher in Psychology, Special Education, Education, Counseling, Social Work or Gerontology.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania, Washington DC, Virginia or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of the Respite service have automobile insurance.

7. Have documentation that all vehicles used in the provision of the Respite service have current State motor vehicle registration and inspection.

8. Have Workers' Compensation Insurance in accordance with state law.

9. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant to carry out the service plan and medical plan which includes but is not limited to communication, mobility, behavioral, and medical needs.

10. Comply with Department standards related to provider qualifications.

Staff working for or contracted with the agency as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Complete necessary pre/in service training based on the service plan.

3. Have at least a high school diploma for participants authorized to receive 2:1 enhanced Respite. The other staff member must have a certification.

4. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

6. Have a valid driver's license if the operation of a vehicle is necessary to provide Respite services.

The provider must maintain documentation that staff (working for or contracted with the agency) meet the following requirements prior to rendering Respite services to participants with a medically complex condition:
1. Have a high school diploma or equivalent.
2. Have received training by a medical professional that is specific to the participant’s medical needs prior to rendering the service on:
a. Specialized equipment that is medically necessary for the health and safety of the participant including, but not limited to, ventilators, suction machines, other respiratory and oxygen supplying equipment, monitoring equipment, and equipment for mobility and transferring.
b. Nutritional, hydration, and special diet needs;
c. Fall prevention;
d. Risk factors and monitoring for skin integrity;
e. Risk factors and monitoring for urinary tract infections;
f. Medical plan related to elimination assistance, urinary and bowel functioning; and
g. Appropriate age and developmental needs of the child.

Further, nursing staff that are providing care to individuals with a medically complex condition may not engage in areas of highly specialized practice, including the practices areas listed below, without the knowledge of and skill in the practice areas involved required by their professional license.

- Tracheostomy;
- Ventilator;
- Suction Machines;
- Other respiratory and oxygen supplying equipment; or
- Intravenous medication.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Individual

**Provider Type:**

Support Service Professional

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Enhanced levels of service are based on the participant's behavioral or medical support needs. Effective 1/1/18, at least one Support Service Professional providing enhanced levels of Respite must have one of the following professional certifications or degrees:

- NADD Competency-Based Clinical Certification;
- NADD Competency-Based Dual Diagnosis Certification;
- NADD Competency-Based Direct-Support Professional Certification;
- Registered Behavior Technician;
- Certified Nursing Assistant;
- Board Certified Assistant Behavior Analyst; or
- Bachelor’s Degree or higher in Psychology, Special Education, Education, Counseling, Social Work or Gerontology.

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

Support Service Professionals must meet the following:
1. Be at least 18 years of age.

2. Complete necessary pre/in service training based on the service plan.

3. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

4. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

5. Have documentation that all vehicles used in the provision of the Respite service have automobile insurance.

6. Have documentation that all vehicles used in the provision of the Respite service have current State motor vehicle registration and inspection.

7. Be trained to meet the needs of the participant to carry out the service plan which includes but is not limited to communication, mobility and behavioral needs.

8. Have at least a high school diploma for participants authorized to receive 2:1 enhanced Respite. The other staff member must meet the requirements in the certificate section above.

9. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS or VF/EA FMS

**Frequency of Verification:**

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

## 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 Camp Agency

**Provider Qualifications**

**License** *(specify):*

For children (under age 21) with medical needs who require Respite by a nurse, at least one staff person (direct, contracted, or in a consulting capacity) who provides enhanced levels of service must be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) when the participant has been assessed to have medical needs that require a RN or LPN.

**Certificate** *(specify):*

Enhanced levels of service are based on the participant's behavioral or medical support needs. Effective 1/1/18, at least on staff (direct, contracted, or in a consulting capacity) providing enhanced levels of Respite must have one of the following professional certifications or degrees:

- NADD Competency-Based Clinical Certification;
- NADD Competency-Based Dual Diagnosis Certification;
- NADD Competency-Based Direct-Support Professional Certification;
- Registered Behavior Technician;
- Certified Nursing Assistant;
- Board Certified Assistant Behavior Analyst; or
- Bachelor’s Degree or higher in Psychology, Special Education, Education, Counseling, Social Work or Gerontology.

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

Respite camp agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania, Washington DC, Virginia or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of the Respite service have automobile insurance.

7. Have documentation that all vehicles used in the provision of the Respite service have current State motor vehicle registration and inspection.

8. Have Workers' Compensation Insurance in accordance with state law.

9. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant to carry out the service plan which includes but is not limited to communication, mobility and behavioral needs.

10. Comply with Department standards related to provider qualifications.

Staff working for or contracted with the agency as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Complete necessary pre/in service training based on the service plan.

3. Have at least a high school diploma for participants authorized to receive 2:1 enhanced Respite. The other staff member must meet the requirements in the certificate section above.

4. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

6. Have a valid driver's license if the operation of a vehicle is necessary to provide Respite services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS, VF/EA FMS, OHCDS, ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

## C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Supported Employment

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 03 Supported Employment | 03010 job development |
| **Category 2:** | **Sub-Category 2:** |
| 03 Supported Employment | 03021 ongoing supported employment, individual |
| **Category 3:** | **Sub-Category 3:** |
| 03 Supported Employment | 03030 career planning |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Supported Employment services are direct and indirect services that are provided in a variety of community settings for the purposes of supporting participants in obtaining and sustaining competitive integrated employment. Direct Supported Employment services may be provided using remote technology in accordance with ODP policy. Competitive integrated employment refers to full or part-time work at minimum wage or higher, with wages and benefits similar to workers without disabilities performing the same work, and fully integrated with coworkers without disabilities.

Supported Employment services include activities such as training and additional supports including worksite orientation, job aide development, coordination of accommodations and ensuring assistive technology that may be needed by the participant to obtain and sustain competitive integrated employment is utilized as specified in the plan. Payment will be made only for the training and supports required by the participant and will not include payment for the training or supervisory activities that should be rendered as a normal part of the job.

Federal Financial Participation through the Waiver may not be claimed for incentive payments, subsidies, or unrelated vocational expenses such as the following:

• Incentive payments made to an employer of participants receiving services to encourage or subsidize the employer's participation in a supported employment program;

• Payments that are passed through to participants receiving Supported Employment; or

• Payments for vocational training that are not directly related to a participant's Supported Employment program.

Supported Employment services consist of three components: career assessment, job finding or development, and job coaching and support.

CAREER ASSESSMENT

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Career assessment is a person-centered, individualized employment assessment used to assist in the identification of potential career options, including self-employment, based upon the interests and strengths of the participant. Career assessment may include discovery activities and may be provided within a variety of settings including residential habilitation settings when identified as a need in the service plan or vocational facilities and adult training facilities when these facilities are where the person’s employment or volunteer experience occurred that is being assessed and when identified as a need in the service plan. Career assessment activities, on average, should be authorized no longer than 6 consecutive months and should result in the development of a career assessment report. When a participant requires career assessment activities in excess of 6 consecutive months, an explanation of why the activities are needed for an extended period of time should be included in the service plan.

Career assessment includes:

• Gathering and conducting a review of the participant’s interests, skills, and work or volunteer history.

• Conducting situational assessments to assess the participant’s interest and aptitude in a particular type of job.

• Conducting informational interviews.

• Identifying types of jobs in the community that match the participant’s interests, strengths and skills.

• Developing a career assessment report that specifies recommendations regarding the participant’s needs, interests, strengths, and characteristics of potential work environments. The career assessment report must also specify training or skills development necessary to achieve the participant’s career goals.

JOB FINDING OR DEVELOPMENT

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Job finding or development includes employer outreach and orientation, job searching, job development, resume preparation and interview assistance. Other activities may include participation in individual planning for employment, development of job-seeking skills, development of job skills specific to a job being sought, job analysis, consulting with the Office of Vocational Rehabilitation (OVR), benefits counseling agencies, or Ticket to Work employment networks on behalf of a participant, or self-employment assistance. Job finding or development may be provided in a variety of settings including residential habilitation settings when identified as a need in the

service plan. The direct portion of job finding or development may not be provided in a vocational facility or adult training facility.

Job finding or development may include customized job development. Customized job development means individualizing the employment relationship between employees and employers in a way that matches the needs of the employer with the assessed strengths, skills, needs, and interests of the participant, either through task reassignment, job carving, or job sharing. Job finding or development may also include negotiating the conditions for successful employment with a prospective employer including tasks, wages, hours and support.

JOB COACHING AND SUPPORT

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Job coaching and support consists of training the participant on job assignments, periodic follow-up, or ongoing support with participants and their employers. This may include systematic instruction. The service must be necessary for participants to maintain acceptable job performance and work habits, including assistance in learning new work assignments, maintaining job skills, and achieving performance expectations of the employer. Other examples of activities include direct intervention with an employer, employment-related personal skills instruction, support to re-learn job tasks, training to assist participants in using transportation to and from work, worksite orientation, job aide development, coordination of accommodations, ensuring assistive technology is utilized as specified in the plan, maintenance of appropriate work and interpersonal behaviors on the job, follow-along services at the work site after OVR-funded services are discontinued or OVR referral requirements are satisfied, and technical assistance and instruction for the participant's coworkers that will enable peer support.

Job coaching and support may not be provided in a vocational facility, adult training facility, Child Residential and Day Treatment Facilities (55 Pa. Code Chapter 3800), Community Residential Rehabilitation Services for the Mentally Ill residential programs (55 Pa. Code Chapter 5310) or any licensed or unlicensed home that provides residential habilitation services funded by ODP.

As part of a participant's ongoing use of job coaching and support, it is expected that the provider will develop a fading plan or fading schedule that will address how use of this service will decrease as the participant's productivity and independence on the job increases and as he or she develops unpaid supports through coworkers and other on-the-job resources. Ongoing use of job coaching and support is limited to providing supports for participants not otherwise available through the employer such as support offered through regular supervisory channels, reasonable accommodation required under the Americans with Disabilities Act, available and appropriate natural supports, or on-the-job resources available to employees who do not have a disability.

Career assessment and job finding or development may be provided at the following levels:

- Basic - Staff-to-individual ratio of 1:1.

Job coaching and support may be provided at the following levels:

- Basic - Staff-to-individual ratio range of 1:2.

- Level 1 - Staff-to-individual ratio of 1:1.

Supported Employment services may not be rendered under the Waiver until it has been verified that:

- The services are not available in the student's (if applicable) complete and approved Individualized Education Program (IEP) developed pursuant to IDEA;

- OVR has closed the participant's case or has stopped providing services to the participant;

- The participant is determined ineligible for OVR services; or

- It has been determined that OVR services are not available. If OVR has not made an eligibility determination within 120 days of the referral being sent or a participant has received an offer of competitive integrated employment prior to OVR making an eligibility determination, then OVR services are considered to not be available to the participant.

A participant does not need to be referred to OVR if:

- The participant is competitively employed and solely needs extended supports to maintain the participant's

current job.

• The participant is competitively employed and is seeking job assessment or job finding services to find a new job, unless the purpose is job advancement which can be provided by OVR.

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

Documentation referenced above must be maintained in the file of each participant receiving Supported Employment services.

It is not allowable for providers of Supported Employment services to also be the employer of the participant to whom they provide Supported Employment services.

Behavioral Support may be provided at the same time as Supported Employment if the need is documented in the service plan.

The direct portion of Supported Employment may not be provided at the same time as any of the following: In-Home and Community Support; Community Participation; 15-minute unit Respite; Small Group Employment; Benefits Counseling; Transportation; Therapies; Education Support; Music, Art and Equine Assisted Therapy and Consultative Nutritional Services. Transportation costs associated with driving the participant to and from activities related to Supported Employment are included in the rate for this service. As such, providers of Supported Employment services are responsible for any needed transportation of the participant to complete Supported Employment activities, with the exception of driving the participant to his or her place of employment.

Companion services may be provided at the same time as Supported Employment for the purpose of supporting the participant with non-skilled activities, supervision and/or incidental personal care that cannot, or would be inappropriate to, be provided with the support from coworkers or other natural supports and is outside the scope of the Supported Employment service. Documentation must be maintained in the service plan about the methods that were considered and/or tried to support the non-skilled activities, supervision and/or incidental personal care needs at the job site before it was determined that Companion services were necessary to enable the participant to sustain competitive integrated employment.

Participants authorized to receive Supported Employment services may not be authorized to receive Advanced Supported Employment.

Supported Employment 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:**

When Supported Employment services are not provided with any other employment service (Small Group Employment, Advanced Supported Employment or Community Participation Support) and the participant is not competitively employed, the hours of authorized Supported Employment cannot exceed 40 hours (160 15-minute units) per participant per calendar week based on a 52-week year.

When Supported Employment services are provided in conjunction with Community Participation Support and/or Small Group Employment the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 50 hours (200 15-minute units) per participant per calendar week based on a 52-week year.

When the participant is competitively employed, the total number of hours for Supported Employment, Community Participation Support and/or Small Group Employment (whether utilized alone or in conjunction with one another) cannot exceed 50 hours (200 15-minute units) per participant per calendar week based on a 52-week year.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Agency |
| Individual | Support Service Professional |
| Individual | Individual |

## 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:**

Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Staff working directly with the participant must have one of the following by 7/1/19 or within six months of hire if hired after 1/1/19:

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

• Have been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.

Effective 7/1/19, newly hired staff who do not have the required certification when hired must work under the supervision of someone who is certified. This can occur no longer than six months from the date of hire to allow the new staff time to obtain the certification.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of the Supported Employment have automobile insurance.

7. Have documentation that all vehicles used in the provision of the Supported Employment service have current State motor vehicle registration and inspection.

8. Have Workers' Compensation Insurance in accordance with state law.

9. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant to carry out the service plan which includes but is not limited to communication, mobility and behavioral needs.

10. Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be 18 years of age.

2. Complete necessary pre/in-service training based on the service plan.

3. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

4. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

5. Have a valid driver's license if the operation of a vehicle is necessary to provide Supported Employment services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Supported Employment**

**Provider Category:**

Individual

**Provider Type:**

Support Service Professional

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Support Service Professionals must have one of the following by 7/1/19 or within six months of hire if hired after 1/1/19:

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

• Have been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.

Effective 7/1/19, newly hired Support Service Professionals who do not have the required certification when hired must work under the supervision of someone who is certified. This can occur no longer than six months from the date of hire to allow the new Support Service Professional time to obtain the certification.

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

Support Service Professionals must meet the following standards:

1. Be 18 years of age.

2. Complete necessary pre/in-service training based on the service plan.

3. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

4. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

5. Have documentation that all vehicles used in the provision of the Supported Employment service have automobile insurance.

6. Have documentation that all vehicles used in the provision of the Supported Employment service have current State motor vehicle registration and inspection

7. Have a valid driver's license if the operation of a vehicle is necessary to provide Supported Employment services.

8. Be trained to meet the needs of the participant to carry out the service plan which includes but is not limited to communication, mobility and behavioral needs.

9. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS or VF/EA FMS

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Supported Employment**

**Provider Category:**

Individual

**Provider Type:**

Individual

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Individuals must have one of the following by 7/1/19 or within six months of hire if hired after 1/1/19:
• Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE); or

• Have been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.

Effective 7/1/19, newly hired individuals who do not have the required certification when hired must work under the supervision of someone who is certified. This can occur no longer than six months from the date of hire to allow the new individual time to obtain the certification.

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

Individuals must meet the following:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Be at least 18 years of age.

6. Complete necessary pre/in-service training based on the service plan.

7. Have criminal history clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

8. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

9. Have documentation that all vehicles used in the provision of the Supported Employment service have automobile insurance.

10. Have documentation that all vehicles used in the provision of the Supported Employment service have current State motor vehicle registration and inspection.

11. Have a valid driver's license if the operation of a vehicle is necessary to provide Supported Employment services.

12. Have Workers' Compensation Insurance in accordance with state law.

13. Be trained to meet the needs of the participant to carry out the service plan which includes but is not limited to communication, mobility and behavioral needs.

14. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## 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 is a critical service that involves the primary functions of locating, coordinating, and monitoring needed services and supports for participants. This includes locating, coordinating and monitoring needed services and supports when a participant is admitted to a nursing home for less than 30 days or a hospital for any duration of time.

The most important element of quality support coordination is building relationships. When strong relationships are developed the quality of supports and services improves. Building relationships is not a separate and distinct activity; it is integral to each function the support coordinator performs.

Locating services and supports consists of assistance to the participant and his or her family in linking, arranging for, and obtaining services specified in the service plan, including resources in the community, competitive integrated employment, needed medical, social, habilitation, and participant direction opportunities.

Activities under the locating function include all of the following, as well as the documentation of the activities:

• Assist the participant in choosing people to be part of the service plan team;

• Assist the participant to invite other people of the participant's choice who may contribute valuable information during the planning process;

• Engage in meaningful conversations with the participant and his or her family, providers and others who provide support to develop, update, and implement the service plan;

• Link support needs of the participant and his or her family identified in the service plan with resources in the community;

• Research existing and identify new resources in the community;

• Gather and share information with which to identify needs and concerns and build partnerships in support of the participant and his or her family;

• Inform participants, their families and other caregivers about the use of unpaid, informal, generic, and specialized services and supports that are necessary to address the identified needs of the participant and to achieve the outcomes specified in the service plan;

• Assist the participant and his or her family in identifying and choosing willing and qualified providers;

• Make referrals to providers (unpaid or paid) with information and follow-up support;

• Participate in the ODP standardized needs assessment process to inform development of the service plan, including any necessary service plan updates;

• Facilitate the completion of additional assessments, based on participants' strengths, needs and preferences for planning purposes and service plan development;

• Provide participants and his or family with information on competitive integrated employment during the planning process and upon request;

• Provide participants and their families or other caregivers with information on participant direction opportunities, including the potential benefits and risks associated with directing services, during the planning process and upon request;

• Provide participants and their families or other caregivers with the standard ODP information about participant direction, an explanation of the options and the contact information for the Financial Management Services provider; and

• Provide information to participants and his or her family on fair hearing rights and assist with fair hearing requests when needed and upon request.

Coordinating consists of development and ongoing management of the service plan in cooperation with the participant, his or her family, and members of the service plan team. Activities under the coordinating function include all of the following, as well as the documentation of the activities:

• Use a person centered planning approach and a team process to develop the participant's service plan to promote community integration and to meet the participant's needs in the least restrictive manner;

• Review and update the participant's service plan annually;

• Revise the participants service plan when there is a change in need or at the request of the participant and his or her family;

• Use information from the life course framework that helps lead to the good life that the participant and his or her family envision and assist with the development of the participants service plan, including any updates to the service plan;

• Use information from the ODP standardized needs assessment, as well as any additional assessments completed to develop the service plan to ensure the service plan addresses all of the participant's needs;

• Periodic review of the service plan with the participant, his or her family, and/or members of the service plan team;

• Periodic review of the standardized needs assessment with the participant and his or her family, at least annually or more frequently based on changes in a participant's needs, to ensure the assessment is current;

• Coordinate service plan planning with providers of service and other entities, resources and programs as necessary to ensure all areas of the participant's needs are addressed;

• Collaborate with his or her family, friends, and other community members to facilitate coordination of the participant's natural support network and develop supporting partnerships in order for the participant to have a good life;

• Coordinate meetings with participant and his or her family with other participants and his or her family receiving services from the providers under consideration and who would be willing to give consent to share their experiences about those providers;

• Coordinate meetings between the participant and his or her family members and provider management staff to discuss provider practices in delivering services;

• Coordinate the resolution of barriers to service delivery;

• Distribute information to participants, his or her family and others who are responsible for planning and implementation of services and support; and

• Assist with the transition to the participant direction service delivery model if the participant is interested in this model, and ensure continuity of services during transition.

Monitoring consists of ongoing contact with the participant and his or her family, to ensure services are implemented as per the service plan. Monitoring is intended to ensure that participants and his or her family are getting the support they need, when they need them, in order to see measurable improvements in their lives. Activities under the monitoring function include all of the following, as well as the documentation of the activities:

• Monitor the health and welfare of participants through regular contacts at the minimum frequency outlined in Appendix D-2-a of this Waiver or increased monitoring frequency based on the need of the participant. Monitoring the health and welfare of participants includes the review of information in health risk screening tools, when applicable, or whether there have been any changes in orders, plans or medical interventions prescribed or recommended by medical or behavioral professionals and whether those changes are being implemented;

• Monitor service plan implementation through monitoring visits with the participant, at the minimum frequency

outlined in Appendix D-2-a of this Waiver or increased monitoring frequency based on the need of the participant;

• Visit with the participant and his or her family, and providers of service for monitoring of health and welfare and service plan implementation;

• Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health and welfare of participants;

• Review participant progress on outcomes and initiate service plan team discussions or meetings when services are not achieving desired outcomes;

• Monitor participant and his or her family satisfaction with services;

• Arrange for modifications in services and service delivery, as necessary to address the needs of the participant, and modify the service plan accordingly;

• Ensure that services are identified in the service plan;

• Work with the authorizing entity regarding the authorization of services on an ongoing basis and when issues are identified regarding requested services;

• Communicate the authorization status to service plan team members, as appropriate;

• Validate that service objectives and outcomes are consistent with the participant’s needs and desired outcomes;

• Advocate for continuity of services, system flexibility and community integration, proper utilization of facilities and resources, accessibility, and participant rights; and

• Participate in activities related to Independent Monitoring for Quality, such as obtaining consent to participate from the participant, preparing survey information, and follow up activities ("closing the loop") and other activities as identified by ODP.

The following activities are excluded from Supports Coordination as a billable Waiver service:
• Intake for purposes of determining whether a participant has an intellectual disability and qualifies for Medical Assistance;

• Conducting Medicaid eligibility certification or recertification, intake processing, Medicaid pre-admission screening for inpatient care, prior authorization for Medicaid services, and Medicaid outreach (methods to inform or persuade individuals to enter into care through the Medicaid system);

• Any function that is delegated to the Supports Coordination Organization by an Administrative Entity;

• Direct Prevention Services, which are used to reduce the probability of the occurrence of an intellectual disability resulting from social, emotional, intellectual, or biological disorders;

• Travel time incurred by the Supports Coordinator may not be billed as a discrete unit of service;

• Services otherwise available under the MA State Plan and other programs;

• Services that constitute the administration of foster care programs;

• Services that constitute the administration of another non-medical program such as child welfare or child protective services, parole and probation functions, legal services, public guardianship, and special education;

• Direct delivery of medical, educational, social, or other services;

• Delivery of medical treatment and other specialized services including physical or psychological examinations or evaluations;

• The actual cost of the direct services other than Supports Coordination that the Supports Coordinator links, arranges, or obtains on behalf of the participant;

• Transportation provided to participants to gain access to medical appointments or direct Waiver services other than Supports Coordination;

• Representative payee functions; and

• Assistance in locating and/or coordinating burial or other services for a deceased participant.

Supports Coordination services may not duplicate other direct Waiver services.

During temporary travel Supports Coordination may be provided in Pennsylvania or other locations as per the ODP travel policy.

• The actual cost of the direct services other than Supports Coordination that the Supports Coordinator links, arranges, or obtains on behalf of the participant;

• Transportation provided to participants to gain access to medical appointments or direct Waiver services other than Supports Coordination;

• Representative payee functions; and

• Assistance in locating and/or coordinating burial or other services for a deceased participant.

Supports Coordination services may not duplicate other direct Waiver services.

During temporary travel Supports Coordination may be provided in Pennsylvania or other locations as per the ODP travel policy.

**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 |
|---|---|
| Agency | Supports Coordination Organization |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Supports Coordination**

**Provider Category:**

Agency

**Provider Type:**

Supports Coordination Organization

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Supports Coordination Organizations must meet the following standards during the initial qualification process:

1. The Executive Director must have five years of professional level experience in the field of disability services, including three years of administrative, supervisory, or consultative work; and a bachelor's degree.

2. The Executive Director must have knowledge of ODP's intellectual disability and autism service system and successfully completes ODP's SCO Applicant Orientation to Enrollment and Provision of Quality Services.

Supports Coordination Organizations must meet the following standards during the initial and ongoing qualification process:
1. Have a waiver service location in Pennsylvania.

2. Function as a conflict free entity. A conflict-free SCO, for purposes of this service definition, is an independent, separate, or self-contained agency that does not have a fiduciary relationship with an agency providing direct services and is not part of a larger corporation. To be conflict free, an SCO may not provide direct or indirect services to participants. The following are considered direct and indirect services:

Direct Services:
• All intellectual disability services provided to base-funded individuals and waiver participants with the exception of Waiver Supports Coordination, Targeted Service Management and State-funded Case Management as well as transportation and ICF/ID services where the SCO shares a Federal Employer Identification Number (FEIN) with the provider.

Indirect Services:
• All services related to Health Care Quality Units, Independent Monitoring Teams, Financial Management Service Providers/Organizations for Waiver participants, and the Statewide Needs Assessment with the exception of Family Driven Support Service funds and the administration of Money Follows the Person (MFP) as approved by CMS.

An SCO may become an Organized Health Care Delivery System (OHCDS) for any vendor service authorized in the participant's ISP. A participant's SCO may not own or operate providers of vendor services with which it is acting as an OHCDS. SCOs must enroll and qualify as an OHCDS and comply with all requirements regarding OHCDS in Appendix I-3-g-ii of the current approved Waivers, as well as 55 Pa. Code § 6100.803.

3. Have conflict of interest disclosure statements that address unbiased decision making by the SCO, managers and staff.

4. Have a Board composed of a maximum of 49% of members who have a business or fiduciary relationship with a direct provider of Consolidated, P/FDS, or ID Base Services other than Supports Coordination or Targeted Service Management.

5. Have a written conflict of interest policy for their Board of Directors and employees.

6. Have an annual training plan to improve the knowledge, skills and core competencies of SCO personnel.

7. Have an orientation program that includes the following:

• Person-centered practices including respecting rights, facilitating community integration, supporting families, honoring choice and supporting individuals in maintaining relationships.

• The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance

with 35 P.S. § 10225.701-708, 6 Pa.Code Chapter 15, 23 Pa.C.S. §§ 6301-6385, Chapter 3490, 35 P.S. §§ 10210.101-704 and applicable adult protective services regulations.

• Individual rights.

• Recognizing and reporting incidents.

8. Personnel must be employees of the SCO.

• Only under extraordinary circumstances can an SCO contract with an agency to provide temporary SC services and must ODP prior approval.

9. Each SC Supervisor can supervise a maximum of seven Supports Coordinators.

10. Have designated SCO personnel for claim submission, reconciliation of claims, and management of denied claims.

11. Meet the requirements for operating a not-for-profit, profit, or governmental organization in Pennsylvania.

12. Have current State motor vehicle registration and inspection for all vehicles owned, leased, and/or hired and used as a component of the Supports Coordination service.

13. Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Supports Coordination service.

14. Have Commercial General Liability Insurance or provide evidence of self-insurance as specified by insurance standards.

15. Have Workers' Compensation Insurance in accordance with state law.

16. Have sufficient SCO personnel to carry out all functions to operate.

17. Comply with and meet all standards of ODP's SCO monitoring process including:

• Timely submission of self-assessment tool,

• Overall compliance score of 86% or higher, and

• Comply with ODP's Corrective Action Plan and Directed Corrective Action Plan process.

18. Ensure 24-hour access to SCO personnel (via direct employees or a contract) for response to emergency situations that are related to the Supports Coordination service or other waiver services.

19. Have the ability to utilize ODP's Information System to document and perform Supports Coordination activities.

20. Cooperate with and assist, as needed, ODP and any state and federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting Medicaid fraud and abuse.

21. Cooperate with Health Care Quality Units, independent monitoring teams, and other external monitoring conducted by ODP's designees.

22. Participate in established AE forums to address risk management, systemic issues and provider viability concerns.

23. Comply with HIPAA.

24. Comply with Department standards related to SCO qualification and enrollment.

Minimum Qualifications for SC Supervisors:

1. Must have knowledge of Pennsylvania's intellectual disability and autism service system which includes successful completion of:

• Person-Centered Thinking training

• Person-Centered Planning training

2. Must meet the following educational and experience requirements:

• A bachelor’s degree with a major coursework in sociology, social welfare, psychology, gerontology, criminal justice or other related social sciences; and two years’ experience as a Supports Coordinator; or

• Have a combination of experience and education equaling at least six years of experience in public or private social work including at least 24 college-level credit hours in sociology, social work, psychology, gerontology or other related social science

3. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

4. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

5. Have a valid driver’s license if the operation of a vehicle is necessary to provide Support Coordination services.

6. Complete a minimum of 24 hours of training each year

Minimum Qualifications for Supports Coordinators:

1. Meet the following minimum educational and experience requirements:

• A bachelor’s degree, which includes or is supplemented by at least 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social science; or

• Two years’ experience as a County Social Service Aide 3 and two years of college level course work, which include at least 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social service; or

• Any equivalent combination of experience and training which includes 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social service and one year of experience as a County Social Services Aide 3 or similar position performing paraprofessional case management functions.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

4. Have a valid driver’s license if the operation of a vehicle is necessary to provide Support Coordination services.

5. Newly hired Supports Coordinators will successfully complete ODP required SC Orientation Curriculum.

6. Complete a minimum of 24 hours of training a year.

24. Comply with Department standards related to SCO qualification and enrollment.

Minimum Qualifications for SC Supervisors:

1. Must have knowledge of Pennsylvania's intellectual disability and autism service system which includes successful completion of:

• Person-Centered Thinking training

• Person-Centered Planning training

2. Must meet the following educational and experience requirements:

• A bachelor’s degree with a major coursework in sociology, social welfare, psychology, gerontology, criminal justice or other related social sciences; and two years’ experience as a Supports Coordinator; or

• Have a combination of experience and education equaling at least six years of experience in public or private social work including at least 24 college-level credit hours in sociology, social work, psychology, gerontology or other related social science

3. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

4. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

5. Have a valid driver’s license if the operation of a vehicle is necessary to provide Support Coordination services.

6. Complete a minimum of 24 hours of training each year

Minimum Qualifications for Supports Coordinators:

1. Meet the following minimum educational and experience requirements:

• A bachelor’s degree, which includes or is supplemented by at least 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social science; or

• Two years’ experience as a County Social Service Aide 3 and two years of college level course work, which include at least 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social service; or

• Any equivalent combination of experience and training which includes 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social service and one year of experience as a County Social Services Aide 3 or similar position performing paraprofessional case management functions.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

4. Have a valid driver’s license if the operation of a vehicle is necessary to provide Support Coordination services.

5. Newly hired Supports Coordinators will successfully complete ODP required SC Orientation Curriculum.

6. Complete a minimum of 24 hours of training a year.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP

**Frequency of Verification:**

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

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Specialized Supplies

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 14 Equipment, Technology, and Modifications | 14032 supplies |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Specialized Supplies consist of incontinence supplies that are medically necessary and are not a covered service through the MA State Plan, Medicare or private insurance. Supplies are limited to diapers, incontinence pads, cleansing wipes, underpads, and vinyl or latex gloves.

This service is not available to participants who reside in licensed or unlicensed residential habilitation settings.

Specialized Supplies can only be provided to adult waiver participants (participants age 21 and older). All medically necessary Specialized Supplies for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Specialized Supplies may only be funded for adult participants if documentation is secured by the Supports Coordinator that shows the supplies are medically necessary and either not covered by the participant's insurance or insurance limitations have been reached. A participant's insurance includes Medical Assistance (MA), Medicare and/or private insurance.

During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

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

This service is limited to $500 per participant per fiscal year.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Supplier |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Specialized Supplies**

**Provider Category:**

Agency

**Provider Type:**

Supplier

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania. (A company that the provider secures the item(s) from can be located anywhere.)

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS, VF/EA FMS, OHCDS, ODP or its Designee

**Frequency of Verification:**

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

## 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:**

Therapy Services

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 11 Other Health and Therapeutic Services | 11080 occupational therapy |
| **Category 2:** | **Sub-Category 2:** |
| 11 Other Health and Therapeutic Services | 11090 physical therapy |
| **Category 3:** | **Sub-Category 3:** |
| 11 Other Health and Therapeutic Services | 11100 speech, hearing, and language therapy |

**Service Definition** *(Scope):*

| **Category 4:** | **Sub-Category 4:** |
| --- | --- |
| 11 Other Health and Therapeutic Services | 11130 other therapies |

Therapy services include the following:

• Physical therapy based on a prescription for a specific therapy program by a physician.

• Occupational therapy based on a prescription for a specific therapy program by a physician.

• Speech/language therapy based on an evaluation and recommendation by an American Speech Language Hearing Association (ASHA) certified and state licensed speech-language pathologist or a physician.

• Orientation, mobility and vision therapy based on an evaluation and recommendation by a trained mobility specialist/instructor or a physician.

Therapy services are direct services provided to assist participants in the acquisition, retention, or improvement of skills necessary for the participant to live and work in the community, and must be attached to a participant's outcome as documented in his or her service plan. Training caretakers and development and monitoring of a home program for caretakers to implement the recommendations of the therapist are included in the provision of Therapy services. Direct Therapy services may be provided using remote technology in accordance with ODP policy. The need for the service must be documented by a professional as noted above for each service and must be evaluated at least annually, or more frequently if needed, as part of the service plan process. This evaluation must review whether the participant continues to require the current level of authorized services and that the service continues to result in positive outcomes for the participant. It is recognized, however, that long-term Therapy services may be necessary due to a participant's extraordinary medical or behavioral conditions. The need for long-term Therapy services must be documented in the participant's service plan.

Physical Therapy: The Physical Therapy Practice Act (63 P.S. §1301 et seq.) defines physical therapy as follows: "means the evaluation and treatment of any person by the utilization of the effective properties of physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and rehabilitative procedures including training in functional activities, with or without assistive devices, for the purpose of limiting or preventing disability and alleviating or correcting any physical or mental conditions, and the performance of tests and measurements as an aid in diagnosis or evaluation of function."

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

Speech and Language Therapy: Services provided by a licensed and American Speech-Language-Hearing Association (ASHA) certified speech-language pathologist to participants with a wide variety of speech, language, and swallowing differences and disorders. Communication includes speech production and fluency, language, cognition, voice, resonance, and hearing. Swallowing includes all aspects of swallowing, including related feeding behaviors. Speech and language therapy includes:

• Counseling participants, families and caregivers regarding acceptance, adaptation, and decision making about communication, feeding and swallowing, and related disorders.

• Prevention and wellness activities that are geared toward reducing the incidence of a new disorder or disease, identifying disorders at an early stage, and decreasing the severity or impact of a disability associated with an existing disorder or disease.

• Screening participants for possible communication, hearing, and/or feeding and swallowing disorders.

• Assessing communication, speech, language and swallowing disorders. The assessment process includes

evaluation of body function, structure, activity and participation, within the context of environmental and personal factors.

• Developing and implementing treatment to address the presenting symptoms or concerns of a communication or swallowing problem or related functional issue. Treatment establishes a new skill or ability or remediates or restores an impaired skill or ability.

• Teaching American Sign Language or another form of communication to an adult waiver participant (a participant who is 21 years of age or older) who is deaf and has been assessed as benefitting from learning American Sign Language or another form of communication is covered under Speech and Language Therapy. Consultation regarding the communication needs of a participant who has nontraditional communication needs is also included under Speech and Language Therapy.

Orientation, mobility and vision therapy: This therapy is for participants who are blind or have visual impairments. The provision of therapy is for the purpose of increasing participants' travel skills and/or access to items used in activities of daily living. This service may include evaluation and assessment of participants and the environments in which they interact, direct service (face-to-face) to participants, and training of support individuals. The provision of this service may result in recommendations for adapting environments or purchasing assistive technology.

Therapy services can only be provided to adult participants (participants age 21 and older). All medically necessary Therapy services for children under age 21 are covered through Medical Assistance pursuant to the EPSDT benefit. Further, Therapy services delivered to adult participants must differ in scope from therapy services covered by Medical Assistance. Therapy services must be delivered in a home and community-based setting and cannot be provided in a clinic or rehabilitative facility setting. Therapy services may only be funded for adult participants if documentation is secured by the Supports Coordinator that shows the service is medically necessary and either not covered by the participant’s insurance or insurance limitations have been reached. A participant’s insurance includes Medical Assistance (MA), Medicare and/or private insurance.

Participants authorized to receive Therapy services may not receive the direct portion of following services at the same time as this service: Community Participation Support; Shift Nursing; Consultative Nutritional Services; Benefits Counseling; Behavioral Support; Supported Living; Supported Employment; Small Group Employment; Music, Art and Equine Assisted Therapy; Education Support and Transportation.

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

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

**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 | Orientation, Mobility and Vision Therapist |
| Individual | Speech Language Therapist |
| Agency | Speech Language Therapy Agency |

| Provider Category | Provider Type Title |
|---|---|
| Agency | Orientation, Mobility and Vision Therapy Agency |
| Agency | Occupational Therapy Agency |
| Individual | Physical Therapist |
| Agency | Physical Therapy Agency |
| Individual | Occupational Therapist |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Therapy Services**

**Provider Category:**

Individual

**Provider Type:**

Orientation, Mobility and Vision Therapist

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

To provide Orientation, Mobility and Vision Therapy, an individual must be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP)as one of the following:
• Certified Low Vision Therapist;

• Certified Orientation and Mobility Specialist; or

• Certified Vision Rehabilitation Therapist.

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

An individual must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

6. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

7. Have Workers' Compensation Insurance, in accordance with state law.

8. Have training to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

9. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Therapy Services**

**Provider Category:**

Individual

**Provider Type:**

Speech Language Therapist

**Provider Qualifications**

**License** *(specify):*

To provide Speech/Language Therapy, an individual must be a state licensed speech-language pathologist.

**Certificate** *(specify):*

An individual therapist must be ASHA certified.

Individuals who teach American Sign Language to participants must have at a minimum, Qualified Level Certification from the American Sign Language Teachers Association (ASLTA).

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

An individual therapist must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

6. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

7. Have at least Advanced or higher Sign Language Skills as determined by the Sign Language Proficiency Interview (SLPI) when the therapist is teaching a participant who is deaf.

8. Have expertise in deafness when working with a participant who is deaf.

9. Have Workers' Compensation Insurance, in accordance with state law.

10. Have training to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

11. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Therapy Services**

**Provider Category:**

Agency

**Provider Type:**

Speech Language Therapy Agency

**Provider Qualifications**

**License** *(specify):*

Staff (direct, contracted, or in a consulting capacity) providing Speech/Language Therapy must be licensed as speech-language pathologists.

**Certificate** *(specify):*

Staff (direct, contracted, or in a consulting capacity) providing Speech/Language Therapy must be ASHA certified.

Staff who teach American Sign Language to participants must have at a minimum, Qualified Level Certification from the American Sign Language Teachers Association (ASLTA).

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance, in accordance with state law.

7. Ensure that staff(direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

Therapists working for or contracted with agencies must meet the following standards:
1. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

2. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

3. Have at least Advanced or higher Sign Language Skills as determined by the Sign Language Proficiency Interview (SLPI) when the therapist is teaching a participant who is deaf.

4. Have expertise in deafness when working with a participant who is deaf.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Therapy Services**

**Provider Category:**

Agency

**Provider Type:**

Orientation, Mobility and Vision Therapy Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Staff (direct, contracted, or in a consulting capacity) providing Orientation, Mobility and Vision therapy must be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) as one of the following:
• Certified Low Vision Therapist;

• Certified Orientation and Mobility Specialist; or

• Certified Vision Rehabilitation Therapist.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance, in accordance with state law.

7. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

Therapists working for or contracted with agencies must meet the following standards:
1. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

2. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Therapy Services**

**Provider Category:**

Agency

**Provider Type:**

Occupational Therapy Agency

**Provider Qualifications**

**License** *(specify):*

Staff (direct, contracted, or in a consulting capacity) providing Occupational Therapy must be licensed as Occupational Therapists.

**Certificate** *(specify):*

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance, in accordance with state law.

7. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

Occupational Therapists working for or contracted with agencies must meet the following standards:
1. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

2. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

# Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Therapy Services**

**Provider Category:**

Individual

**Provider Type:**

Physical Therapist

**Provider Qualifications**

**License** *(specify):*

To provide Physical Therapy, an individual must be a licensed physical therapist.

**Certificate** *(specify):*

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

An individual must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

6. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

7. Have Workers' Compensation Insurance, in accordance with state law.

8. Have training to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

9. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

# Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Therapy Services**

**Provider Category:**

Agency

**Provider Type:**

Physical Therapy Agency

**Provider Qualifications**

**License** *(specify):*

Staff (direct, contracted, or in a consulting capacity) providing Physical Therapy must be licensed as Physical Therapists.

**Certificate** *(specify):*

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance, in accordance with state law.

7. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

Physical therapists working for or contracted with agencies must meet the following standards:
1. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

2. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

# Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Therapy Services**

**Provider Category:**

Individual

**Provider Type:**

Occupational Therapist

**Provider Qualifications**

**License** *(specify):*

To provide Occupational Therapy the individual must be a licensed Occupational Therapist.

**Certificate** *(specify):*

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

The occupational therapist must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

6. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

7. Have training to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

# 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:**

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**

Information and Assistance in Support of Participant Direction

**Alternate Service Title (if any):**

Supports Broker Services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 12 Services Supporting Self-Direction | 12020 information and assistance in support of self-direction |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

The Supports Broker service is a direct and indirect service available to participants who elect to self-direct their own services utilizing one of the participant directed options outlined in Appendix E-1 of the Waiver. The Supports Broker service is designed to assist participants or their designated surrogate with employer-related functions in order to be successful in self-directing some or all of the participants needed services. Direct Supports Broker services may be provided using remote technology in accordance with ODP policy.

This service is limited to the following list of activities:

• Explaining and providing support in completing employer-or managing employer related paperwork.

• Participating in Financial Management Services (FMS) orientation and other necessary trainings and interactions with the FMS provider.

• Developing effective recruiting and hiring techniques.

• Determining pay rates for Support Service Professionals.

• Providing or arranging for training for Support Service Professionals.

• Developing schedules for Support Service Professionals.

• Developing, implementing and modifying a back-up plan for services, staffing for emergencies and/or Support Service Professional absences.

• Scheduling paid and unpaid supports.

• Developing effective management and supervision techniques such as conflict resolution.

• Developing proper procedures for termination of Support Service Professionals in the VF/EA FMS option or communication with the Agency With Choice regarding the desire for removal of Support Service Professionals from working with the participant in the AWC FMS option.

• Reviewing of workplace safety issues and strategies for effective management of workplace injury prevention.

• Assisting the participant or their designated surrogate in understanding and/or fulfilling the responsibilities outlined in the Common Law Employer Agreement form and the Managing Employer Agreement form.

• Facilitating a support group that helps to meet the participant’s self-direction needs. These support groups are separate and apart from the service plan team meetings arranged and facilitated by the Supports Coordinator.

• Expanding and coordinating informal, unpaid resources and networks within the community to support success with participant direction.

• Identifying areas of support that will promote success with self-direction and independence and share the information with the team and Supports Coordinator for inclusion in the service plans.

• Identifying and communicating any proposed modifications to the participant’s service plan.

• Advising and assisting with the development of procedures to monitor expenditures and utilization of services.

• Complying with the standards, regulations, policies and the waiver requirements related to self-direction.

• Advising in problem-solving, decision-making, and achieving desired personal and assessed outcomes related to the participant directed services.

• When applicable, securing a new surrogate and responding to notices for corrective action from the FMS, SC, AE or ODP.

• All functions performed by a Supports Broker must be related to the personal and assessed outcomes related to

the participant directed services in the service plan.

The following Supports Broker activities may be completed while a participant is hospitalized in accordance with Section 1902(h) of the Social Security Act, when the services are identified in the participant's service plan:
- Developing schedules for Support Service Professionals.
- Assisting managing employers and common law employers to ensure that Support Service Professionals are trained and scheduled to support the participant's needs when hospitalized and to support a smooth transition of the participant from the hospital to a home and community-based setting.

Supports Brokers must work collaboratively with the participant's Supports Coordinator and service plan team. Supports Brokers may not replace the role of, or perform the functions of a Supports Coordinator. The role of the Supports Coordinator continues to involve providing the primary functions of locating, coordinating, and monitoring of waiver services; while the Supports Broker assists participants or their designated surrogate with assistance with the above noted functions. No duplicate payments will be made.

Supports Broker Services may be provided by individual and agency providers that provide other Waiver, intellectual disability or autism services but the Supports Broker provider must be conflict free. In order to be conflict free, the Supports Broker provider may not provide other direct or indirect waiver services or base funded intellectual disability services when authorized to provide Support Broker services to the participant. In addition, Supports Broker providers may not provide administrative services such as Health Care Quality Unit or Administrative Entity functions. However, an IM4Q program may provide Supports Broker services to participants who they are not responsible for interviewing.

The VF/EA FMS is required to provide the VF/EA FMS administrative service and pay for all identified participant directed services authorized for a participant who is self-directing through the VF/EA FMS Intermediate Services Organization Provider Type. Self-directing participants in the VF/EA FMS program may employ Supports Brokers through a Common-Law Employer relationship; when this occurs, Supports Brokers will be considered "Support Service Professionals" (SSP) for the purposes of this definition.

AWC FMS providers are required to provide AWC FMS administrative services in addition to all identified participant directed waiver services authorized for a participant who is self-directing through an AWC FMS provider. As such, the AWC FMS provider is able to provide both Supports Broker services and other participant directed waiver services to the same participant, but only as an AWC FMS Intermediate Services Organization Provider Type.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

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

This service is limited to a maximum of 1040 (15-minute) units, which is equal to 260 hours, per participant per fiscal year.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Supports Brokerage Agency |

| Provider Category | Provider Type Title |
|---|---|
| Individual | Support Service Professional |
| Individual | Supports Broker |

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**
**Service Name: Supports Broker Services**

**Provider Category:**

Agency

**Provider Type:**

Supports Brokerage Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Staff (direct, contracted, or in a consulting capacity) must successfully complete a Supports Broker Certification Program provided by ODP or its Designee to provide Supports Broker services. Staff hired on or after the effective date of this waiver must successfully complete the Supports Broker Certification Program prior to enrollment as a Supports Broker. Staff hired prior to the effective date of this waiver must complete this program by 1/1/19.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of the Supports Broker service have automobile insurance.

7. Have documentation that all vehicles used in the provision of the Supports Broker service have current State motor vehicle registration and inspection

8. Have Workers' Compensation Insurance in accordance with state law.

9. Comply with Department standards related to provider qualifications.

Staff working for or contracted with the agency as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

4. Have a valid driver's license, if the operation of a vehicle is necessary to provide Supports Broker services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**
**Service Name: Supports Broker Services**

**Provider Category:**

Individual

**Provider Type:**

Support Service Professional

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Support Service Professionals must successfully complete a Supports Broker Certification Program provided by ODP or its designee. Support Service Professionals that enroll on or after the effective date of this waiver must complete this program prior to enrollment as a Supports Broker. Support Service Professionals that are enrolled prior to the effective date of this waiver must complete this program by 1/1/19.

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

Support Service Professionals must meet the following standards:
1. Be at least 18 years of age.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

4. Have documentation that all vehicles used in the provision of the Supports Broker service have automobile insurance.

5. Have documentation that all vehicles used in the provision of the Supports Broker service have current State motor vehicle registration and inspection.

6. Have a valid driver's license, if the operation of a vehicle is necessary to provide Supports Broker services.

7. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS or VF/EA FMS

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**
**Service Name: Supports Broker Services**

**Provider Category:**

Individual

**Provider Type:**

Supports Broker

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

An individual Supports Broker must successfully complete a Supports Broker Certification Program provided by ODP or its designee. Individual Supports Brokers that enroll on or after the effective date of this waiver must complete this program prior to enrollment as a Supports Broker. Individual Supports Brokers that are enrolled prior to the effective date of this waiver must complete this program by 1/1/19.

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

An individual Supports Broker must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Be at least 18 years of age.

6. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

7. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

8. Have documentation that all vehicles used in the provision of the Supports Broker service have automobile insurance.

9. Have a valid driver's license, if the operation of a vehicle is necessary to provide Supports Broker services.

10. Have documentation that all vehicles used in the provision of the Supports Broker service have current State motor vehicle registration and inspection.

11. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## 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:**

Advanced Supported Employment

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 03 Supported Employment | 03010 job development |
| **Category 2:** | **Sub-Category 2:** |
| 03 Supported Employment | 03021 ongoing supported employment, individual |
| **Category 3:** | **Sub-Category 3:** |
| 03 Supported Employment | 03030 career planning |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Advanced Supported Employment is an enhanced version of supported employment services provided by qualified providers. The service includes discovery, job development, systematic instruction to learn the key tasks and responsibilities of the position and intensive job coaching and supports that lead to job stabilization and retention.

DISCOVERY
---
Discovery is a targeted service for a participant who wishes to pursue competitive integrated employment but, due to the impact of their disability, their skills, preferences, and potential contributions cannot be best captured through traditional, standardized means, such as functional task assessments, situational assessments, and/or traditional normative assessments which compare the participant to others or arbitrary standards of performance and/or behavior.

Discovery involves a comprehensive analysis of the participant in relation to the following:
• Strongest interests toward one or more specific aspects of the labor market;

• Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment; and

• Conditions necessary for successful employment or self-employment.

Discovery includes the following activities: observation of the participant in familiar places and activities, interviews with family, friends and others who know the participant well, observation of the participant in an unfamiliar place and activity, identification of the participant's strong interests and existing strengths and skills that are transferable to individualized integrated employment or self-employment. Discovery also involves identification of conditions for success based on experience shared by the participant and others who know the participant well, and observation of the participant during the Discovery process. The information developed through Discovery allows for activities of typical life to be translated into possibilities for individualized competitive integrated employment or self-employment.

JOB ACQUISITION
---
Job development, which can include customized employment or self-employment, is based on individualizing the employment relationship between employees and employers and negotiating on behalf of the participant in a way that matches the needs of the employer with the assessed strengths, skills, needs, and interests of the participant.

Systematic instruction refers to a strategic, carefully-planned sequence for instruction, from simple to complex, with clear and concise objectives driven by ongoing assessment. It is carefully thought out and designed before work commences.

JOB RETENTION
---
Intensive job coaching includes assisting the participant in meeting employment expectations, performing business functions, addressing issues as they arise, and also includes travel training and diversity training to the specific business where the participant is employed. It provides support to assist participants in stabilizing a competitive integrated job (including self-employment) including ongoing support and may include activities on behalf of the participant to assist in maintaining job placement.

Eligibility for Advanced Supported Employment is limited to participants whose preferences, skills, and employment potential cannot be best determined through traditional, standardized means due to the impact of their disability. Specifically, the participant:
1. Has been found ineligible for or has a closed case with Office of Vocational Rehabilitation (OVR) services and chooses not to be re-referred or 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; and

2. Has never had job skills training or development, has never had any work related experiences (including volunteer experiences) or in the past 2 years, with the use of Supported Employment services, has not been able to secure a

competitive integrated job or has not been able to keep a competitive integrated job for more than 6 months; and

3. Meets one of the following criteria:
a. Is currently in an activity receiving a sub-minimum wage; or

b. After consulting with a credentialed provider, it is the opinion of the service plan team that the level of support provided through this service is needed to secure sustained competitive integrated employment.

In addition to the criteria above, to be eligible for job development, systematic instruction or intensive job coaching under Advanced Supported Employment, the participant must have received the discovery service under Advanced Supported Employment through its completion or the completion of the discovery/profile phase through OVR and the case was closed.

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

Advanced Supported Employment services furnished under the waiver may not include services available under section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17).

Advanced Supported Employment is paid on an outcome basis. Providers are paid for three separate outcomes.
1. Discovery Portfolio - The production of a detailed written Discovery Profile, using a standard template prescribed by the Department or one that meets the professional credential required for this service, which summarizes the process, learning and recommendations to inform identification of the participant's individualized goal(s) and strategies to be used in securing competitive integrated employment, and the production of a visual resume and individualized plan for employment, using a standard template prescribed by the Department or one that meets the professional credential required for this service.

2. Securing a Job - A job evidenced by an offer letter, email, documented phone call or other documentation from an employer offering the participant employment that meets the definition of competitive integrated employment or evidence of self-employment.

3. Retention of Job - Successful retention on the job, evidenced by the participant working a minimum of 5 hours per week for at least 4 months.

Discovery activities may be provided within a variety of settings including residential habilitation settings when identified as a need in the service plan or vocational facilities and adult training facilities when these facilities are where the participant's employment or volunteer experience occurred that is being assessed and when identified as a need in the service plan. The direct provision of job acquisition activities may not be provided in a vocational facility or adult training facility. Job retention activities may not be provided in a Vocational Facility (55 Pa. Code Chapter 2390), Adult Training Facility (55 Pa. Code Chapter 2380), Child Residential and Day Treatment Facilities (55 Pa. Code Chapter 3800), Community Residential Rehabilitation Services for the Mentally Ill (55 Pa. Code Chapter 5310) or any licensed or unlicensed home that provides residential habilitation services funded by ODP.

Behavioral Support may be provided at the same time as Advanced Supported Employment if the need is documented in the service plan.

The direct provision of job acquisition and job retention may not be provided at the same time as the direct provision of any of the following: In-Home and Community Supports; Community Participation Support; Small Group Employment; Benefits Counseling; 15-minute unit Respite; Transportation; Therapies; Education Support and Music, Art and Equine Assisted Therapy.

Participants authorized to receive Advanced Supported Employment services may not be authorized to receive Supported Employment services during the same time period.

Companion may be provided at the same time as Advanced Supported Employment for the purpose of supporting the participant with non-skilled activities, supervision and/or incidental personal care that cannot, or would be inappropriate to, be provided with the support from coworkers or other natural supports and is outside the scope of the Advanced Supported Employment service. Documentation must be maintained in the service plan about the methods that were considered and/or tried to support the non-skilled activities, supervision and/or incidental personal care at the job site before it was determined that Companion was necessary to enable the participant to sustain competitive integrated employment.

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 |
|---|---|
| Agency | Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Advanced Supported Employment**

**Provider Category:**

Agency

**Provider Type:**

Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Staff (direct, contracted or in a consulting capacity) who will work directly with the participant to provide Advanced Supported Employment services shall hold one of the following:
1. Bachelor's Degree; or

2. High school diploma and at least four years of consecutive or non-consecutive years of personal experience as a parent, sibling or primary caretaker of an individual with an intellectual disability, autism, or other disability that involved significant medical, physical, cognitive or developmental challenges; or

3. High school diploma and at least four years of professional experience providing services to people with an intellectual disability, autism, or other disability that involved significant medical, physical, cognitive or developmental challenges as a service coordinator, staff person, SC, supervisor, or rehabilitation professional; or

4. A combination of post-secondary education without a Bachelor's Degree combined with either personal or professional experience that totals at least four years.

In addition to the education and experience requirements listed above, staff who will work directly with the participant must also have an Advanced Supported Employment certification, which is in good standing, by an ODP-recognized training organization. To be recognized by ODP, the Advanced Supported Employment certification must meet all of the following criteria:
1. Require at least 20 hours of classroom instruction;

2. Require at least 40 hours of supervised, mentored field work;

3. Include competency-based testing;

4. Require certification renewal at least every 3 years; and

5. Be nationally recognized and acceptable to ODP.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania, Washington DC, Virginia or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of the Advanced Supported Employment have automobile insurance.

7. Have documentation that all vehicles used in the provision of the Advanced Supported Employment service have current State motor vehicle registration and inspection.

7. Have Workers' Compensation Insurance, in accordance with state law.

8. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

9. Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Complete necessary pre/in-service training based on the service plan.

3. Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

4. Have child abuse clearance (when the participant is under age 18) as per 23 Pa. C.S. Chapter 63.

5. Have a valid driver's license if the operation of a vehicle is necessary to provide Advanced Supported Employment services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## 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 | 14010 personal emergency response system (PERS) |
| **Category 2:** | **Sub-Category 2:** |
| 14 Equipment, Technology, and Modifications | 14031 equipment and technology |
| **Category 3:** | **Sub-Category 3:** |
| | |

**Service Definition** *(Scope):*

| Category 4: | Sub-Category 4: |
|---|---|
| | |

An item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve a participant's functioning or increase a participant's ability to exercise choice and control. Assistive Technology services include direct support in the selection, acquisition, or use of an assistive technology device, limited to:

• Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the participant;

• Selecting, designing, fitting, customizing, adapting, installing, maintaining, repairing, or replacing assistive technology devices. Repairs are only covered when it is more cost effective than purchasing a new device and are not covered by a warranty;

• Training or technical assistance for the participant, or where appropriate, the participant's family members, guardian, advocate, staff or authorized representative on how to use and/or care for the assistive technology;

• Extended warranties; and

• Ancillary supplies, software, and equipment necessary for the proper functioning of assistive technology devices, such as replacement batteries and materials necessary to adapt low-tech devices.

Electronic devices that are separate from independent living technology are included under Assistive Technology to meet a communication or prompting need. Examples of electronic devices include: tablets, computers and electronic communication aids. There must be documentation that the device is a cost effective alternative to a service or piece of equipment. When multiple devices are identified as being effective to meet the participant's need, the least expensive option must be chosen. Applications for electronic devices that assist participants with a need identified are also covered for participants.

Generators are covered for the participant's primary private home. Generators are not covered for any home other than the participant's primary private residence.

Independent living technology is included for participants age 16 and older. The purpose of independent living technology is to assist participants in obtaining and or maintaining their independence and safety within their home and community and decrease their need for assistance from others. Independent living technology involves the use of remote monitoring services and/or equipment in conjunction with additional technological support and services. Examples of equipment and services covered as independent living technology include: medication dispensers, door sensors, window sensors, stove sensors, water sensors, pressure pads, GPS Tracking Watches, panic pendants and the remote monitoring equipment necessary to operate the independent living technology. This service includes the costs for delivery, installation, adjustments, monthly testing, monitoring, maintenance and repairs to the independent living technology equipment.

Independent living technology is fully integrated into the participant's overall system of support. Prior to purchasing and installing remote monitoring equipment the independent living technology provider is responsible for the completion of the following:

• An evaluation plan that, at a minimum, includes: the need(s) of the participant that will be met by the technology; how the technology will ensure the participant's health, welfare and independence; the training needed to successfully utilize the technology and the back-up plan that will be implemented should there be a problem with the technology.

• A cost benefit analysis for all options. If the participant is receiving waiver services prior to receiving independent living technology, the cost benefit analysis must show how the technology will substitute for at least an equivalent amount of waiver services within 60 calendar days after installation, training and full use by the participant has begun. If the participant is not receiving waiver services prior to receiving independent living technology, the cost benefit analysis must show how the technology is more cost effective than waiver services.

• An outcome monitoring plan that outlines the outcomes the participant is to achieve by using independent living technology, how the outcomes will be measured and the frequency that the monitoring will be completed which must be at least quarterly and more frequently if needed.

• Informing the participant, and anyone identified by the participant, of what impact the independent living technology will have on the participant's privacy. This information must be provided to the participant in a form of

communication reasonable calculated to be understood by the individual. After this has been completed, the independent living technology provider must then obtain either the participant's consent in writing or the written consent of a legally responsible party for the participant. This process must be completed prior to the utilization of independent living technology and any time there is a change to the independent living devices or services.

This information will be provided to the participant and service plan team for discussion and inclusion of the technology in the service plan.

Once the independent living technology has been approved on the service plan, the independent living technology provider is responsible for the following:
• Training the participant, family, natural supports and any support professionals that will assist the participant in the use of the equipment initially and ongoing as needed.

• Delivery of the equipment to the participant's residence and when necessary, to the room or area of the home in which the equipment will be used.

• Installation of the equipment, including assembling the equipment or parts used for the assembly of the equipment.

• Adjustments and modifications of the equipment.

• Transferring the equipment to a new home when the participant moves. This only applies when the new home is in an area served by the provider.

• Conducting monthly testing of the equipment to ensure the equipment is in good working condition and is being used by the participant. For remote monitoring devices that are in daily use there will be a means to continuously monitor the functioning of the devices and a policy or plan in place to address malfunctions.

• Maintenance and necessary repairs to the equipment. Replacement of equipment is covered when the device no longer meets the participant's needs, is obsolete, functionally inadequate, unreliable, or no longer supported by the manufacturer.

• If the assessment identifies a need for remote monitoring, ensure the remote monitoring equipment meets the following:
o Includes an indicator that lets the participant know that the equipment is on and operating. The indicator shall be appropriate to meet the participant's needs.
o Is designed so that it can be turned off only by the person(s) indicated in the service plan.
o Has 99% system uptime that includes adequate redundancy.
o Has adequate redundancy that ensures critical system functions are restored within three hours of a failure. If a service is not available, the provider must be alerted within ten minutes.
o If the assessment identifies the need for a staffed call center, a backup plan must be in place that meets the needs of the participant. In the most demanding situation that may mean that there is another call center that is part of a network. In less demanding situations, it may be an alternate location that can become operational within a time frame that meets the needs of the participant. In any event, an adequate "system down" plan must be in place.
o If a main hub is part of the installed system it should be A/C powered, and include a backup battery capable of maintaining a charge to ensure the continued connectivity of the remote monitoring equipment if power loss occurs. There will be a mechanism to alert staff when a power outage occurs that provides a low battery alert, and an alert if the system goes down so that back-up support, if required, are put in place until service is restored. A main hub, if required, must be able to connect to the internet via one or more different methods; hard-wired, wireless, or cellular. The main hub must also have the ability to send via one or more different modes; text, email or audio notifications, as well as the ability, if in the assessment, to connect to an automated or consumer support call center that is staffed 24 hours a day, 7 days a week.
o Has a latency of no more than 10 minutes from when an event occurs to when the notification is sent (via text, email or audio).
o Has the capability to include environmental controls that are able to be added to, and controlled by, the installed independent living technology system if identified in the assessment.
o Have a battery life expectancy lasting six months or longer, and notification must be given if a low battery condition is detected.

All items purchased through Assistive Technology shall meet the applicable standards of manufacture, design, and installation. Items reimbursed with Waiver funds shall be in addition to any equipment or supplies provided under the MA State Plan. Excluded are those items that are not of direct medical or remedial benefit to the participant, or are primarily for a recreational or diversionary nature. Items designed for general use shall only be covered to the extent necessary to meet the participant's needs and be for the primary use of the participant. If the participant receives Behavioral Therapy or Behavioral Support Services, the Assistive Technology must be consistent with the participant's behavior support plan.

Assistive Technology devices (with the exception of independent living technology) 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 professional certified by Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). 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. The evaluation must include the development of a list of all devices, supplies, software, equipment, product systems and/or waiver services (including a combination of any of the elements listed) that would be most effective to meet the need(s) of the participant. The least expensive option from the list must be selected for inclusion on the service plan.

The following list includes items excluded as Assistive Technology (please note this is not an exhaustive list of excluded items):
• Durable medical equipment, as defined by 55 Pa. Code Chapter 1123 and the MA State Plan;
• Hearing aids for children under 21 years of age;
• Air conditioning systems or units, heating systems or units, water purifiers, air purifiers, vaporizers, dehumidifiers, and humidifiers;
• Recreational or exercise equipment; and
• Swimming pools, hot tubs, whirlpools and whirlpool equipment, and health club memberships.

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

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

Assistive Technology has the following limits:
• A lifetime limit of $10,000 per participant for all Assistive Technology except remote monitoring services completed as part of independent living technology. This limit may be extended by ODP using the standard ODP variance process. This lifetime limit includes:

o A lifetime limit of $5,000 for generators for the participant's primary residence only. The lifetime limit on generators may not be extended using the variance process and generators for a secondary residence are not available through the waiver. While generators have a separate lifetime limit, the amount spent on a generator is included in the overall Assistive Technology lifetime limit of $10,000.

o Electronic devices. No more than one replacement electronic device is allowed every 5 years.

o Remote monitoring equipment utilized as part of independent living technology.

o Repairs, warranties, ancillary supplies, software and equipment.

• An annual limit of $5,000 for remote monitoring service completed as part of independent living technology. This limit is not included in the overall Assistive Technology lifetime limit of $10,000.

**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 Living Technology Agency |
| Agency | Agency |

## 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 Living Technology Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

To provide independent living technology, the agency must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania. (The physical location of a company that sells a good may be located anywhere in the United States or the American territories.)

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. Have Commercial General Liability Insurance.

5. Comply with all federal, state and local regulations that apply to the operation of its business or trade, including but not limited to, the Electronic Communications Privacy Act of 1986 and section 2399.52 of the Revised Code.

6. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

7. Have a participant support call center that is staffed 24 hours a day, 7 days a week, or an automated call center if identified in the assessment.

8. Have a policy outlining the process for providing emergency replacement devices or parts within one business day if the devices installed at the participant's residence fail and cannot be repaired if identified in the assessment. If device failure occurs on a weekend or holiday, the replacement devices or parts may require one or two additional business days.

9. Provide access to a secure and encrypted website that displays critical system information about each independent living technology device installed in a participant's residence.

10. Have an effective system for notifying personnel such as police, fire, emergency medical services and psychiatric crisis response entities.

11. Document that any technology system provider utilized to supply remote monitoring equipment meets the following criteria:
- The technology system provider has been in this line of business a minimum of 3 years.
- The technology system provider has 3 references related to the provider's business history and practices.

12. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OHCDS, ODP or its Designee

**Frequency of Verification:**

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

## 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:**

Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

1Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania. (A company that the provider secures the item(s) from can be located anywhere.)

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers Compensation Insurance, in accordance with state law.

7. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OHCDS, ODP or its Designee

**Frequency of Verification:**

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

## 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:**

Behavioral Support

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 10 Other Mental Health and Behavioral Services | 10040 behavior support |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

This is a direct and indirect service that includes a comprehensive assessment; the development of strategies to support the participant based upon the assessment; and the provision of interventions and training to participants, staff, parents and caregivers. Services must be required to meet the current needs of the participant, as documented and authorized in the service plan.

There are two levels of service that reflect differing levels of provider qualifications and participant needs. Participants requiring Level 2 support will have demonstrated complex needs, including regression or lack of adequate progress with Level 1 support, or be deemed at high risk for decreased stability in the absence of Level 2 support.

Behavioral Support services includes both the development of (1) an initial behavioral support plan by the Behavioral Specialist and (2) ongoing behavioral support:
1. During initial behavioral support plan development the Behavioral Specialist must:
• Conduct a comprehensive assessment of behavior and its causes and an analysis of assessment findings of the behavior(s) to be targeted so that an appropriate behavioral support plan may be designed.

• Collaborate with the participant, his or her family, and his or her service plan team for the purpose of developing a behavior support plan that must include positive practices and least restrictive interventions. The behavior support plan may not include physical, chemical or mechanical restraints as support strategies.

• Develop an individualized, comprehensive behavioral support plan consistent with the outcomes identified in the participant's service plan, within 60 days of the authorization start date of the Behavioral Support service in the service plan.

• Develop a crisis intervention plan that will identify how crisis intervention support will be available to the participant, how the Supports Coordinator 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.

• Upon completion of initial plan development, meet with the participant, the Supports Coordinator, others as appropriate, including family members, providers, and employers to explain the behavioral support plan and the crisis intervention plan to ensure all parties understand the plans.

2. Ongoing Behavioral Support: Ongoing support can occur both before and after the completion of the behavioral support plan. If the participant needs Behavioral Support before the behavioral support plan and crisis intervention plan are developed, the Supports Coordinator must document the need for support. Upon completion of the initial behavioral support plan, the Behavioral Specialist provides direct and consultative supports.

Ongoing Behavioral Support includes the following:
• Collection and evaluation of data;

• Conducting comprehensive functional assessments of presenting issues (e.g. aggression, self-injurious behavior, law offending behavior [sexual or otherwise]);

• Updating and maintenance of behavior support plans, which utilize positive strategies to support the participant, based on functional behavioral assessments;

• Development of a fading plan for restrictive interventions;

• Conducting training and support related to the implementation of behavior support plans for the participant, family members, staff and caretakers;

• Implementation of activities and strategies identified in the participant's behavior support plan, which may include providing direct behavioral support, educating the participant and supporters regarding the underlying causes/functions of behavior and modeling and/or coaching of supporters to carry out interventions;

• Monitoring implementation of the behavior support plan, and revising as needed; and

• Completion of required paperwork related to data collection, progress reporting and development of annual planning material.

Behavioral Support services can only be provided to adult participants. All necessary Behavioral Support services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Behavioral Support services do not include the provision of therapy or counseling.

Services may be provided in the office of the Behavioral Specialist, the participant's home, or in local public community environments necessary for the provision of the Behavioral Support Services. Direct services must be provided on a one-on-one basis. Direct Behavioral Support services may be provided using remote technology in accordance with ODP policy.

Behavioral Support services may also be delivered in a hospital, in accordance with Section 1902(h) of the Social Security Act, when the services are:
- Identified in the participant's service plan;
- Provided to meet needs of the participant that are not met through the provision of hospital services;
- Designed to ensure smooth transitions between the hospital and home and community-based settings, and to preserve the participant's functional abilities; and
- Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or state law, or under another applicable requirement.

This service can only be provided in a hospital setting to assist the participant with one or more of the following:
- Communication; or
- Behavioral support/stabilization as enumerated in the behavior support plan.

Behavioral Support may be provided at the same time as Advanced Supported Employment, Supported Employment or Small Group Employment if the participant needs the service at his or her place of employment to maintain employment as documented in the service plan.

The direct provision of Behavioral Support may not be provided at the same time as the direct provision of Therapy services.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

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

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Licensed Behavioral Support Specialist |
| Agency | Behavior Support Agency |

# Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Behavioral Support**

**Provider Category:**

Individual

**Provider Type:**

Licensed Behavioral Support Specialist

**Provider Qualifications**

**License** *(specify):*

A licensed behavioral support specialist must be licensed as one of the following:
• Licensed as a psychiatrist in the state where services are provided;

• Licensed as a psychologist in the state where services are provided;

• Licensed as a professional Counselor in the state where services are provided;

• Licensed as a masters level social worker in the state where services are provided; or

• Pennsylvania Behavior Specialist License.

**Certificate** *(specify):*

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

A licensed behavioral support specialist must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have criminal history clearances per 35 P.S. 10225.101 et seq. and 6 Pa. Code Chapter 15.

7. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

8. Complete training in conducting and using a Functional Behavioral Assessment.

9. Complete training in positive behavioral support.

10. Have at least 2 years' experience in working with people with an intellectual disability or autism.

11. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Behavioral Support**

**Provider Category:**

Agency

**Provider Type:**

Behavior Support Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Behavioral Specialists providing Level 1 must meet the professional education or licensure criteria in one of the following three sets of requirements:
1. Master’s Degree or higher in Psychology, Special Education, Counseling, Social Work, Education, Applied Behavior Analysis or Gerontology.

2. A Pennsylvania Behavior Specialist License.

3. Bachelor’s Degree and work under the supervision of a professional who has a Master’s Degree in Psychology, Special Education, Counseling, Social Work, Education, Applied Behavior Analysis or Gerontology, or who is a licensed psychiatrist, psychologist, professional counselor, social worker (master's level or higher) or who has a Pennsylvania Behavior Specialist License.

Behavioral Specialists providing Level 2 must meet the professional education or licensure criteria in one of the following two sets of requirements:
1. Master’s Degree in Psychology, Special Education, Counseling, Social Work, Education Applied Behavior Analysis or Gerontology.

2. Licensed psychiatrist, psychologist, professional counselor or social worker (master's level or higher) or a Pennsylvania Behavior Specialist License.

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

The agency must meet the following Standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance, in accordance with state law.

7. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) as per 23 Pa. C.S. Chapter 63.

4. Complete training in conducting and using a Functional Behavioral Assessment.

5. Complete training in positive behavioral support.

6. Have at least 2 years' experience in working with people with an intellectual disability or autism.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Benefits Counseling

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 13 Participant Training | 13010 participant training |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Benefits Counseling is a direct service designed to inform, and answer questions from, a participant about competitive integrated employment and how and whether it will result in increased economic self-sufficiency and/or net financial benefit through the use of various work incentives. Through an accurate individualized assessment, this service provides information to the participant regarding the full array of available work incentives for essential benefit programs including Supplemental Security Income, SSDI, Medicaid, Medicare, housing subsidies, food stamps, etc.

The service also will provide information and education to the participant regarding income reporting requirements for public benefit programs, including the Social Security Administration.

Benefits Counseling provides work incentives counseling and planning services. It is provided to participants considering or seeking competitive integrated employment or career advancement or to participants who need problem solving assistance to maintain competitive integrated employment.

Benefits Counseling must be provided in a manner that supports the participant's communication style and needs, and shall meet at a minimum what is required under the Americans with Disabilities Act. This service may be provided in person or virtually based on the participant's informed choice, after the pros and cons of each method are explained to the participant.

Benefits Counseling may only be provided after Benefits Counseling services provided by a Certified Work Incentives Counselor through a Pennsylvania-based federal Work Incentives Planning and Assistance (WIPA) program were sought and it was determined and documented by the Supports Coordinator that such services were not available either because of ineligibility or because of wait lists that would result in services not being available within 30 calendar days (this is only required once per year; i.e., it must be repeated if Benefits Counseling is needed in a subsequent year).

Benefits Counseling may not be provided at the same time as the direct provision of any of the following: Small Group Employment, Supported Employment, Advanced Supported Employment, Transportation, Therapies, Education Support, Music, Art Therapy and Equine Assisted Therapy, Consultative Nutritional Services and Communication Specialist.

This service can be delivered in Pennsylvania.

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

Benefits Counseling services are limited to a maximum of 40 (15-minute) units which is equal to 10 hours per participant per fiscal year for any combination of initial benefits counseling, supplementary benefits counseling when a participant is evaluating a job offer/promotion or a self-employment opportunity, or problem-solving assistance to maintain competitive integrated employment.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Benefits Counseling**

**Provider Category:**

Agency

**Provider Type:**

Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Staff (direct, contracted or in a consulting capacity) who will work directly with the participant to provide Benefits Counseling services shall hold a Certified Work Incentives Counselor certification that is accepted by the Social Security Administration for its Work Incentives Planning and Assistance program.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance in accordance with state law.

7. Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

# 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:**

Communication Specialist Services

**HCBS Taxonomy:**

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

| | |
|---|---|
| 17 Other Services | 17020 interpreter |

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

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

**Service Definition** *(Scope):*

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

This is a direct and indirect service that supports participants with nontraditional communication needs by determining the participant's communication needs, educating the participant and his or her caregivers on the participant's communication needs and the best way to meet those needs in their daily lives. Direct Communication Specialist services may be provided using remote technology in accordance with ODP policy.

The service begins with a thorough review of review of the participant's communication needs and skills (both expressive and receptive), including but not limited to the participant's:

- Current methods of communication (how the participant communicates at the time of the assessment);

- Preferred methods of communication (How the participant prefers to communicate);

- Supplementary communication methods;

- Communication methods that have proven to be ineffective in daily communication; and

- Educating caregivers in the participant's current and preferred communication needs.

Once the review is complete, an action plan is developed. The action plan should be person-specific and created with the service plan team. The plan should include:

• The participant's best communication methods, both expressive and receptive;
•Current barriers to effective communication; and
•Measurable steps to address and eliminate the barriers to expressive and receptive communication from all aspects of the participant's everyday life.

At least annually, the action plan should be evaluated for effectiveness and modified if needed.

The service may include one or more of the following activities:

• Helping to establish environments that emphasize the use of visual cues and other appropriate communication methods as recommended by a Speech-Language pathologist or other qualified professional.

• Providing assistance to remove communication barriers.

• Educating SCOs, AEs, and other appropriate entities about a participant's specific needs related to communication access, legal responsibilities and cultural and linguistic needs.

• Participating in and assisting in the development of participants' service plan, as appropriate.

For the purposes of this service, "nontraditional communication" includes the use one or more of the following communication methods:

• Sign Language, including American Sign Language; Sign Language from other countries, such as Spanish Sign Language; Signed Exact English; or a mixture of American Sign Language and signed English.

• Lip Reading.

• Visual-Gestural Communication.

• Paralinguistics.

• Haptics / Touch cues.

• Artifacts, Texture Cues, and/or Objects of Reference.

• Braille.

• Print and Symbol Systems.

• Speech, Voice and Language Interpretation.

• Eye-Gaze and Partner-Assisted Scanning.

• Other communication methods identified by the Department.

For participants who are deaf or hard of hearing, the provider must have the ability to sign at Intermediate Plus level or above as determined by the Sign Language Proficiency Interview.

This service does not include any of the following activities:

• Preventing, screening, identifying, assessing, or treating known or suspected disorders relating to speech, feeding and swallowing, or communication disorders.

• Screening participants for speech, language, voice, or swallowing disorders.

• Teaching participants, families and other caregivers speech reading and speech and language interventions.

• Teaching participants, families and other caregivers and other communication partners how to use prosthetic and adaptive devices for speaking and swallowing.

• Using instrumental technology to provide nonmedical diagnosis, nonmedical treatment and nonmedical services for disorders of communication, voice and swallowing.

• Teaching American Sign Language (ASL) unless the “sign” that is being taught is participant-specific. ASL lessons are not included in the service.

The direct portion of Communication Specialist services cannot be provided at the same time as the direct portion of the following: Benefits Counseling and Consultative Nutritional services.

To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

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

Communication Specialist services are limited to a maximum of 160 (15-minute) units which is equal to 40 hours per participant per fiscal year.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Agency |
| Individual | Communication Specialist |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Communication Specialist Services**

**Provider Category:**

Agency

**Provider Type:**

Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania, Washington D.C., Virginia, or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance, in accordance with state law.

7. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant to carry out the service plan which includes, but is not limited to, communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

Staff working for or contracted with the agency must meet the following standards:
1. Be at least 18 years of age.

2. Have experience in one or more of the following: Speech Language Pathology, sign linguistics, education of deaf, or another relevant professional background.

3. Have personal or professional experience with people with an intellectual disability or autism.

4. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

6. Complete necessary pre/in-service training based on the service plan.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Communication Specialist Services**

**Provider Category:**

Individual

**Provider Type:**

Communication Specialist

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

The Communication Specialist must meet the following standards:
1. Have a waiver service location in Pennsylvania, Washington D.C., Virginia, or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Be at least 18 years of age.

6. Complete necessary pre/in-service training based on the service plan.

7. Be trained to meet the needs of the participant to carry out the service plan which includes, but is not limited to, communication, mobility and behavioral needs.

8. Have experience in one or more of the following: Speech Language Pathology, sign linguistics, education of deaf, or another relevant professional background.

9. Have personal or professional experience with people with an intellectual disability or autism.

10. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

11. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

12. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

# 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:**

Companion

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08040 companion |
| **Category 2:** | **Sub-Category 2:** |
| 08 Home-Based Services | 08030 personal care |
| **Category 3:** | **Sub-Category 3:** |
| | |

**Service Definition** *(Scope):*

| Category 4: | Sub-Category 4: |
|---|---|
| | |

Companion services are direct services provided to participants age 18 and older who live in private homes for the limited purposes of providing supervision or assistance that is designed to ensure the participant's health, safety and welfare and to perform incidental activities of daily living for the participant. This service is intended to assist the individual to participate more meaningfully in home and community life. Direct Companion services may be provided during awake hours using remote technology in accordance with ODP policy. Companion services may not be provided during overnight asleep hours using remote technology.

This service may be provided in home and community settings, including the participant's competitive employment work place. To the extent that Companion services are provided in community settings, the settings must be inclusive rather than segregated. Companion services shall not be provided in a licensed setting, unlicensed residential setting or camp. This does not preclude this service from being utilized to assist a participant to volunteer in a nursing facility or hospital or occasionally visit a friend or family member in a licensed setting or unlicensed residential setting.

Companion services may also be delivered in a hospital in accordance with Section 1902(h) of the Social Security Act, when the services are:

- Identified in the participant's service plan;
- Provided to meet needs of the participant that are not met through the provision of hospital services;
- Designed to ensure smooth transitions between the hospital and home and community-based settings, and to preserve the participant's functional abilities; and
- Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or state law, or under another applicable requirement.

This service can only be provided in a hospital setting to assist the participant with one or more of the following:

- Communication;
- Intensive personal care; or
- Behavioral support/stabilization as enumerated in the behavior support plan.

Companion services are used in lieu of In-Home and Community Support when a habilitative outcome is not appropriate or feasible (i.e. when the professional providing the service mainly does activities for the participant or supervises the participant versus assisting the participant to learn, enhance or maintain a skill). While Companion services are mainly used to provide supervision and assist with socialization, as an incidental part of the service companions may supervise, assist or even perform activities for a participant that include: grooming, household care, meal preparation and planning, ambulating, medication administration in accordance with regulatory guidance.

This service can be used for hours when the participant is sleeping and needs supervision and/or assistance with tasks that do not require continual assistance, or non-habilitative care to protect the safety of the participant. For example, Companion services can be used during overnight hours for a participant who lives on their own but does not have the ability to safely evacuate in the event of an emergency or solely needs routine monitoring for conditions other than post-surgical care and convulsive (grand mal) epilepsy. Effective January 1, 2020, caregivers with whom the participant lives may not provide Companion services when the participant has been sleeping 5 or more hours and does not require direct care or supervision during those asleep hours. When direct care or supervision is provided, the caregiver may be reimbursed.

This service can also be used to supervise participants during socialization or non-habilitative activities when necessary to ensure the participant's safety.

Effective 1/1/18, this service may be provided at the following levels:

- Basic – Staff-to-individual ratio of 1:3.
- Level 1 - Staff-to-individual ratio of 1:2.
- Level 2 - Staff-to-individual ratio of 1:1.

Transportation necessary to enable participation in community activities outside of the home in accordance with the participant's service plan that is 30 miles or less per day is included in the rate paid to agency providers. Mileage that is needed to enable participation in community activities that exceeds 30 miles on any given day should be authorized on the service plan and billed by the agency as Transportation Mile. Transportation is not included in the wage range for Companion services provided by Support Service Professionals in participant directed services. As such, Transportation services should be authorized and billed as a discrete service. When Transportation services are

authorized and billed as a discrete service (regardless of whether the services are delivered by an agency or Support Service Professional) Companion is compensable at the same time for the supervision, assistance and/or care provided to the participant during transportation. Companion services cannot be used to solely transport a participant as this would be considered a Transportation service available in the waiver. The participant must have a need for supervision, assistance or the performance of tasks on his or her behalf while in the home and community locations for which transportation is necessary.

Companion services may not be provided at the same time as the direct portion of the following: Small Group Employment, In-Home and Community Supports, Respite (15 minute unit or Day), Shift Nursing and Community Participation Support.

Companion may be provided at the same time as Supported Employment and Advanced Supported Employment for the purpose of supporting the participant with non-skilled activities, supervision and/or personal care needs that cannot, or would be inappropriate to, be provided with the support from coworkers or other natural supports and is outside the scope of the Supported Employment or Advanced Supported Employment service. Documentation must be maintained in the service plan about the methods that were considered and/or tried to support the non-skilled activities, supervision and/or personal care needs at the job site before it was determined that Companion was necessary to enable the participant to sustain competitive integrated employment.

Companion can only be provided to participants age 18 and older. All medically necessary personal care is covered through Medical Assistance for participants aged 18 to 20 pursuant to the EPSDT benefit and cannot be provided as a part of Companion services. Medically necessary personal care can only be covered for participants aged 21 and older as a part of Companion services.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

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

Companion services that are authorized on a service plan may be provided by relatives/legal guardians of the participant. When this occurs, any one relative or legal guardian may provide a maximum of 40 hours per week of authorized Companion or a combination of Companion and In-Home and Community Support (when both services are authorized in the service plan). Further, when multiple relatives/legal guardians provide the service (s) each participant may receive no more than 60 hours per week of authorized Companion or a combination of Companion and In-Home and Community Support (when both services are authorized in the service plan) from all relatives/legal guardians. An exception may be made to the limitation on the number of hours of In-Home and Community Support and Companion provided by relatives/legal guardians at the discretion of the employer when there is an emergency or an unplanned departure of a regularly scheduled worker for up to 90 calendar days in any fiscal year.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Companion Agency |
| Individual | Support Service Professional |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Companion**

**Provider Category:**

Agency

**Provider Type:**

Companion Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of the Companion service have automobile insurance.

7. Have documentation that all vehicles used in the provision of the Companion service have current State motor vehicle registration and inspection.

8. Have Workers' Compensation Insurance, in accordance with state law.

9. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant to carry out the service plan which includes, but is not limited to, communication, mobility and behavioral needs.

10. Comply with Department standards related to provider qualifications.

Staff working for or contracted with the agency as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Complete necessary pre/in-service training based on the service plan.

3. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

4. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

5. Have a valid driver's license if the operation of a vehicle is necessary to provide Companion services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Companion**

**Provider Category:**

Individual

**Provider Type:**

Support Service Professional

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Support Service Professionals must meet the following standards:
1. Be at least 18 years of age.

2. Complete necessary pre/in-service training based on the service plan.

3. Be trained to meet the needs of the participant to carry out the service plan which includes, but is not limited to, communication, mobility and behavioral needs.

4. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

6. Have documentation that all vehicles used in the provision of the Companion service have automobile insurance.

7. Have a valid driver's license if the operation of a vehicle is necessary to provide Companion services.

8. Have documentation that all vehicles used in the provision of the Advanced Supported Employment service have current State motor vehicle registration and inspection.

9. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS or VF/EA FMS

**Frequency of Verification:**

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

## 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:**

Consultative Nutritional Services

**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):*

Consultative Nutritional Services are direct and indirect services that assist unpaid caregivers and/or paid support staff in carrying out participant treatment/service plan, and that are not covered by the Medicaid State Plan, and are necessary to improve or sustain the participant's health status and improve the participant's independence and inclusion in their community. The service may include assessment, the development of a home treatment/service plan, training and technical assistance to carry out the plan and monitoring of the participant and the provider in the implementation of the plan. Direct Consultative Nutritional Services may be provided using remote technology in accordance with ODP policy. This service may be delivered in the participant's home or in the community as described in the service plan. This service requires a recommendation by a physician.

Training family or other caregivers and development of a home program for caregivers to implement the recommendations of the Licensed Dietitian-Nutritionist are included in the provision of this service.

Consultative Nutritional Services can only be provided to adult participants. All medically necessary Consultative Nutritional Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Consultative Nutritional Services may only be funded for adult participants through the Waiver if documentation is secured by the Supports Coordinator that shows the service is medically necessary and either not covered by the participant's insurance or insurance limits have been reached. A participant's insurance includes Medical Assistance (MA), Medicare and/or private insurance. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

This service cannot be provided in a provider owned, leased, rented or operated licensed or unlicensed setting. This service does not include the purchase of food.

Consultative Nutritional services may only be funded for adult participants age 21 years and older through the Waiver when documentation is secured by the Supports Coordinator that shows the service is medically necessary and either not covered by the participant's insurance or insurance limitations have been reached. A participant's insurance includes Medical Assistance (MA), Medicare and/or private insurance.

Direct Consultative Nutritional services may not be provided at the same time as the direct provision of any of the following: Benefits Counseling; Supported Employment; Small Group Employment; Community Participation Support; 15-minute unit Respite; Shift Nursing; Communication Specialist; Transportation; Therapies; Music, Art and Equine Assisted Therapy and Education Support.

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

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

Consultative Nutritional services are limited to 48 (15-minute) units which is equal to 12 hours per participant per fiscal year.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual Registered Dietician |
| Agency | Registered Dietician Agency |

# Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Consultative Nutritional Services**

**Provider Category:**

Individual

**Provider Type:**

Individual Registered Dietician

**Provider Qualifications**

**License** *(specify):*

Individual Dietitian-Nutritionists must hold a state license in Pennsylvania (Title 49 Pa. Code Chapter 21, subchapter G), or a license in the state where the service is provided

**Certificate** *(specify):*

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

Individuals must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance, in accordance with state law.

7. Be trained to meet the needs of the participant which includes but is not limited to communication, mobility, and behavioral needs.

8. Have criminal history clearances per 35 P.S. 10225.101 et seq. and 6 Pa. Code Chapter 15.

9. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

10. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

# Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Consultative Nutritional Services**

**Provider Category:**

Agency

**Provider Type:**

Registered Dietician Agency

**Provider Qualifications**

**License** *(specify):*

Staff (direct, contracted, or in a consulting capacity) providing Consultative Nutritional Service must hold a state license in Pennsylvania (Title 49 Pa. Code Chapter 21, subchapter G) or a license in the state where the service is provided.

**Certificate** *(specify):*

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance, in accordance with state law.

7. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility, and behavioral needs.

8. Comply with Department standards related to provider qualifications.

Staff working of or contracted with agencies must meet the following standards:
1. Have criminal history clearances per 35 P.S. 10225.101 et seq. and 6 Pa. Code Chapter 15.

2. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## 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 Medical Support Assistance

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| | |

| Category 2: | Sub-Category 2: |
|---|---|
| | |

| Category 3: | Sub-Category 3: |
|---|---|
| | |

**Service Definition** *(Scope):*

| Category 4: | Sub-Category 4: |
|---|---|
| | |

The Family Medical Support Assistance service assists with coordination of services in the participant's home related to the participant's medically complex condition. This is a direct and indirect service that does not involve hands on care. Providers are required to render the following two components of the service.

1. Family support assistant - The family support assistant provides assistance to participants and their families with coordination of unpaid supports and waiver services with skilled nursing, home health, medical services, and behavioral health in the participant's home including:

- Scheduling medical and behavioral health appointments and assisting with medical visits (both in office and via remote technology),

- Understanding the concerns of the participant, family and other designated persons with medical providers or services and assist with mitigating those concerns when possible,

- Directly assisting the participant and his/her designated person(s) with the discharge process from a hospital, clinic, or nursing home setting to return home. The discharge process may include accompanying the designated person(s) to bring the participant home if transportation is an issue, assisting with receiving and educating the designated person(s) and participant on the discharge information, and ensuring that the participant's home is set up for home care and treatment based on the participant's needs.

- Facilitating access to generic community services,

- Assisting with communication with insurance providers to understand coverage and coordination of needed medical services,

- Assisting in obtaining needed medication, supplies, and equipment,

- Identifying barriers that prevent participants from accessing effective and necessary medical services and supports and collaborate with ISP team members regarding possible ways to reduce those barriers,

- Assisting with implementation of the ISP and life course plan with the family, and

- Providing training and consultative assistance on implementation of non-medical aspects of the ISP to the family or Children Youth and Family supervised family and team members; training other staff supports coming into the home on non-medical aspects of the ISP and roles and responsibilities of team members of implementation of non-medical aspects of the ISP.

2. Nursing Oversight - A licensed nurse completes the following activities within the scope of the state's Nurse Practice Act:

- Assessment of the participant's medically complex condition,

- Completion of Health Risk Screening Tool Clinical Reviews in accordance with ODP protocols,

- Identification of training needs related to the participant's medically complex condition and providing training to the participant, unpaid caregivers, and paid professionals,

- Training and consultative assistance on implementation of medical aspects of the ISP to the family or Children Youth and Families supervised family and team members; training other staff supports coming into the home on medical aspects of the ISP and roles and responsibilities of team members of implementation of medical aspects of the ISP,

- Helping the participant, family and any other designated persons or waiver service providers understand the participant's medically complex condition and impact on their behavioral or emotional health,

- Consulting with doctors and other healthcare professionals, and

- Supervision and evaluation of the performance of the participant's medical and/or behavioral health needs or

anything that maintains the participant's best state of health.

Nursing oversight differs from nursing available for children under the state plan in the nature and provider type. State plan coverage provides only for direct nursing services while nursing oversight allows a nurse to train and supervise family or service providers and monitor their provision of these services.

The family support assistant and nurse work as a team to support each participant, family and other supporters and service providers. The family support assistant and nurse will communicate with the Supports Coordinator on a regular basis to ensure that the service plan is up-to-date and that the Supports Coordinator is aware of any needed coordination, location, and/or monitoring of supports and services that fall under the scope of the Supports Coordination service. The family support assistant may provide Family Medical Support Assistance to no more than 8 participants for this or any other service. The nurse consultant may render Family Medical Support Assistance to no more than 16 participants for this or any other service.

Completion of the Health Risk Screening Tool and adherence to Health Risk Screening Tool protocols is required as part of the Family Medical Support Assistance service.

Family Medical Support Assistance is available to participants who live in private homes. This service is not available to participants who receive Life Sharing, Supported Living or Residential Habilitation services.

Relatives who do not live with the participant or are not responsible for direct care of the participant may render this service.

**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 |
|---|---|

## 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/Caregiver Training and 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 training and counseling services for unpaid family members or caregivers who provide support to a participant. For purposes of this service anunpaid family member or caregiver is defined as any person, such as a family member, spouse, neighbor, friend, partner, companion, or co-worker, who provides uncompensated care, training, guidance, companionship or support to the participant.

This service is intended to develop, strengthen and maintain healthy, stable relationships among the participant and all members of the participant's informal network, to support achievement of the goals in the participant's service plan. Family/Caregiver Training and Support also assists the participant's unpaid family member or caregiver with developing expertise so that they can help the participant acquire, retain or improve skills that lead to meaningful engagement and involvement with others and in the community.

Family/Caregiver Training and Support services are intended to increase the likelihood that the participant will remain in or return to the family or unpaid caregiver's home, or so that the participant will successfully live in his or her own home or apartment in the community.

Family/Caregiver Training and Support services must be aimed at assisting unpaid family members or caregivers who support the participant to understand and address the participant's needs and strengthen the relationship between the participant and caregiver. Family/Caregiver Training and Support services must be necessary to achieve the expected outcomes identified in the participant's service plan and must be related to the role of the unpaid family member or caregiver in supporting the participant in areas specified in the service plan.

Emphasis in the Family/Caregiver Training and Support service may address such areas as:

• The acquisition of coping skills by building upon the strengths of the participant and unpaid family member or caregiver;

• Supporting unpaid family members or caregivers to support the participant during times of difficulty, crisis, loss, change, and transition;

• Working with unpaid family members or caregivers to improve communication with and support of one another;

• Coaching unpaid family members or caregivers in acquiring healthy approaches to reducing stress and balancing responsibilities; and

• Other areas so that all unpaid family members or caregivers can most effectively support the desired outcomes of the participant as described in the service plan.

Family/Caregiver Training and Support may include instruction about treatment regimens and other services included in the service plan and includes updates as necessary to safely maintain the participant at home and in the community during transitions throughout the lifespan. Services must be aimed at assisting the unpaid family member or caregiver in meeting the needs of the participant, and all training and counseling needs must be included in the service plan. The Family/Caregiver Training and Support provider must provide this service in a manner consistent with the participant's Behavior Support Plan and Crisis Intervention Plan.

In addition to services available from a qualified provider as described in Provider Specifications below, Family/Caregiver Training and Support may also be achieved through the unpaid family member or caregiver's attendance at specific training events, workshops, seminars or conferences by payment of registration and training fees, provided the formal instruction is relevant to the participant's needs as identified in the service plan. Payment or reimbursement for costs of travel, meals, and/or overnight lodging is not a covered expense.

This service may not be provided in order to train or counsel paid caregivers. The waiver may not pay for services for which a third party, such as the family members' health insurance, is liable. Family/Caregiver Training and Support services do not duplicate mental health services to treat mental illness that Medical Assistance provides through a 1915(b) waiver (Behavioral HealthChoices).

The Family/Caregiver Training and Support provider must maintain documentation on strategies, interventions and progress relating to the stated goals of the service as indicated in the service plan.

Training and counseling provided to unpaid family members or caregivers may be delivered in Pennsylvania and in

states contiguous to Pennsylvania. Registration fees for training opportunities may occur anywhere, however, lodging, meals and transportation are not compensable through the waiver.

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

The amount of training and counseling provided to unpaid family members or caregivers is limited to a maximum of 80 (15-minute) units which is equal to 20 hours per participant per fiscal year. In the event that these services would be needed beyond this limit to assure the participant's health and welfare, based on the unpaid family member or caregiver's request or provider assessment that additional services would be needed, the Supports Coordinator will convene a service plan 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.

The amount of training or registration fees for the unpaid family member or caregiver's registrations costs at specific training events, workshops, seminars or conferences is limited to $500 per participant per fiscal year, provided the formal instruction is relevant to the participant's needs as identified in the service plan. This cannot be used for lodging, meals or transportation.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Licensed Professional Counselor |
| Agency | Training Agency |
| Agency | Professional Counseling Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Family/Caregiver Training and Support**

**Provider Category:**

Individual

**Provider Type:**

Licensed Professional Counselor

**Provider Qualifications**

**License** *(specify):*

The individual who provides training and counseling services must be licensed as one of the following:
• Be a licensed social worker in Pennsylvania (Title 49 Pa. Code Chapter 47) or be a licensed master's level social worker in the state where the service is provided.

• Be a licensed psychologist in Pennsylvania (Title 49 Pa. Code Chapter 41) or be a licensed psychologist in the state where the service is provided.

• Be a licensed professional counselor in Pennsylvania (49 Pa. Code Chapter 49) or be a licensed master's level counselor in the state where the service is provided.

• Be a licensed marriage and family therapist in Pennsylvania (49 Pa. Code Chapter 48) or be a licensed master's level marriage and family therapist in the state where the service is provided

**Certificate** *(specify):*

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

The licensed professional counselor who provides training and counseling services must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have criminal history clearances per 35 P.S. 10225.101 et seq. and 6 Pa. Code Chapter 15.

7. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

8. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Family/Caregiver Training and Support**

**Provider Category:**

Agency

**Provider Type:**

Training Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Training agencies that provide training events, workshops, seminars or conferences must meet the following standards:
1. Have a signed ODP Provider Agreement on file with ODP when the agency directly enrolls with the Department as a provider.

2. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

3. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS, VF/EA FMS, OHCDS, ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Family/Caregiver Training and Support**

**Provider Category:**

Agency

**Provider Type:**

Professional Counseling Agency

**Provider Qualifications**

**License** *(specify):*

Staff working for or contracted with agencies who provide training and counseling services must be licensed as one of the following:

• Be a licensed social worker in Pennsylvania (Title 49 Pa. Code Chapter 47) or be a licensed master's level social worker in the state where the service is provided.

• Be a licensed psychologist in Pennsylvania (Title 49 Pa. Code Chapter 41) or be a licensed psychologist in the state where the service is provided.

• Be a licensed professional counselor in Pennsylvania (49 Pa. Code Chapter 49) or be a licensed master's level counselor in the state where the service is provided.

• Be a licensed marriage and family therapist in Pennsylvania (49 Pa. Code Chapter 48) or be a licensed master's level marriage and family therapist in the state where the service is provided.

**Certificate** *(specify):*

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

Agencies that provide training and counseling services must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance in accordance with state law.

7. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Complete necessary pre/in-service training based on the service plan.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

# 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 Accessibility Adaptations

**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):*

Home accessibility adaptations are an outcome based vendor service that consists of certain modifications to the private home of the participant (including homes owned or leased by parents/relatives/friends with whom the participant resides). The modifications must be necessary due to the participant's disability or medical needs, to ensure the health, security of, and accessibility for the participant, or which enable the participant to function with greater independence in the home. This service may only be used to adapt the participant's primary residence. For participants with a medically complex condition who need home accessibility adaptations to transition from an institutional setting, the adaptations can occur no more than 180 days prior to the participant moving into their primary residence. A provider or OHCDS may not bill for home accessibility adaptations until the participant moves out of the institutional setting and into the participant's primary residence.

Home modifications consist 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 shall meet the applicable standards of manufacture, design, and installation and shall be provided in accordance with applicable building codes.

Modifications to a household subject to funding under the Waivers are limited to the following:

• Accessible alerting systems for smoke/fire/CO2 for individuals with sensory impairments.

• Electronic systems that enable someone with limited mobility to control various appliances, lights, telephone, doors, and security systems in their room, home or other surroundings.

• Widened doorways, landings, and hallways.

• An additional doorway needed to ensure the safe egress of the participant during emergencies, when a variance is approved by the ODP Regional Office (a variance is not required for participants with a medically complex condition).

• Swing clear and expandable offset door hinges.

• Flush entries and leveled thresholds.

• Replacement of glass window panes with a shatterproof or break resistant material for participants with behavioral issues as noted in the participant's service plan.

• Slip resistant flooring.

• Kitchen counter, major appliance, sink and other cabinet modifications.

• Modifications to existing bathrooms for bathing, showering, toileting and personal care needs.

• Bedroom modifications of bed, wardrobe, desks, shelving, and dressers.

• Workroom modifications to desks and other working areas.

• Modifications needed to accommodate a participant's special sensitivity to sound, light or other environmental conditions.

In addition to the modifications listed above, the following home accessibility adaptations are also included for participants with a medically complex condition:

- Air conditioning if the participant has a medical need for specific temperature regulation.
- Electrical rewiring if the participant needs life-support equipment.
- Installation of specialized electric and plumbing systems that are necessary to accommodate the participant's medical equipment and supplies.
- Installation of flooring supports needed to support the weight of the participant's medical equipment.

For home accessibility durable medical equipment used by participants with a mobility impairment to enter and exit their home or to support activities of daily living covered by medical assistance in the state plan (such as ramps, lifts,

stair glides, handrails, and grab bars), Home Accessibility Adaptations shall only include the following:
- Extended warranties for the home accessibility durable medical equipment.
- Repairs of the home, including repairs needed as a result of the installation, use or removal of the home accessibility durable medical equipment or appliance.
- Any of the following required to install home accessibility durable medical equipment:

o Adding internal supports such that the support requires access to the area behind a wall or ceiling or underneath the floor to install home accessibility durable medical equipment.
o Constructing retaining walls or footers for a retaining wall if needed to install home accessibility durable medical equipment.
o Modifications to an existing deck.
o Widening a doorway.
o Upgrades to the home's electrical system.
o Demolition of drywall or flooring.

Home Accessibility Adaptations do not include modifications that:
- Are not specifically identified in the service definition.
- Are not of direct medical or remedial benefit to the participant.
- Are not needed as a result of the participant's medical needs or disability.
- The family or caregiver would be expected to make for an individual without a disability.
- Are for general maintenance of the home.
- Are part of room and board.
- Have a primary benefit for a caregiver, staff person, family member, or the public at large.
- Are used in the construction of a new home or any new room in the home.
- Are durable medical equipment.

Adding to the total square footage to the home is excluded from this service, unless an adaptation to an existing bathroom is needed to complete the home accessibility adaptation (e.g., necessary to configure a bathroom to accommodate a wheelchair).

To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

At least three bids must be obtained for Home Accessibility adaptations that cost more than $1,000. The least expensive bid must be chosen, unless there is documentation from the service plan team that justifies not choosing the lowest bid. If three contractors, companies, etc. cannot be located to complete the Home Accessibility Adaptations, documentation of the contractors or companies contacted must be kept in the participant's file.

This service must be delivered in Pennsylvania.

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

Maximum state and federal funding participation is limited to $20,000 per participant during a 10-year period. The 10-year period begins with the first utilization of authorized Home Accessibility Adaptations. A new $20,000 limit can be applied when the participant moves to a new home or when the 10-year period expires. In situations of joint custody (as determined by an official court order) or other situations where a participant divides their time between official residences, the adaptations must be allowable services and must be completed within the overall monetary limit of $20,000 for this service.

A variance may be requested for the $20,000 limit and approved by ODP for any of the following situations:
- Maintenance or repair to existing home accessibility adaptations when it is not covered by a warranty or home owners insurance and the maintenance or repair is more cost effective than replacing the home accessibility adaptation.
- If the participant has a medically complex condition and there is a change to the participant's medical condition or status that require additional home accessibility adaptations.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual |
| Agency | Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Home Accessibility Adaptations**

**Provider Category:**

Individual

**Provider Type:**

Individual

**Provider Qualifications**

**License** *(specify):*

An individual provider must have a contractor's license for the state of Pennsylvania, if required by trade.

**Certificate** *(specify):*

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

An individual provider must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self- assessment and validation of required documentation, policies and procedures.

5. Comply with the Pennsylvania Home Improvement Consumer Protection Act.

6. Have Workers' Compensation Insurance in accordance state law.

7. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS, VF/EA FMS, OHCDS, ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Home Accessibility Adaptations**

**Provider Category:**

Agency

**Provider Type:**

Agency

**Provider Qualifications**

**License** *(specify):*

An agency must have a contractor's license for the state of Pennsylvania, if required by trade.

**Certificate** *(specify):*

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance in accordance with state law.

7. Comply with the Pennsylvania Home Improvement Consumer Protection Act.

8. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS, VF/EA FMS, OHCDS, ODP or its Designee

**Frequency of Verification:**

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

# 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:**

Housing Transition and Tenancy Sustaining Service

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| | |

| Category 2: | Sub-Category 2: |
|---|---|
| | |

| Category 3: | Sub-Category 3: |
|---|---|
| | |

**Service Definition** *(Scope):*

| Category 4: | Sub-Category 4: |
|---|---|
| | |

This service includes pre-tenancy and housing sustaining supports to assist participants in being successful tenants in private homes owned, rented or leased by the participants.

Housing Transition services are direct and indirect services provided to participants. Indirect activities that cannot be billed include driving to appointments, completing service notes and progress notes, and exploring resources and developing relationships that are not specific to a participant's needs as these activities are included in the rate. The following direct and indirect activities are billable under Housing Transition:

• Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers.

• With the individual, developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.

• Assisting with the housing search process.

• Assisting with the housing application process, including assistance with applying for housing vouchers/applications.

• Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses.

• Ensuring that the living environment is safe and ready for move-in.

• Assisting in arranging for and supporting the details of the move.

• Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized to assist individuals with planning, locating and maintaining a home of their own.

• Assistance with establishing and building a relationship for community integration.

• Assistance with obtaining and identifying resources to assist the participant with financial education and planning for housing. Activities include assistance with budgeting for house and living expenses. Assistance with completing applications for subsidies or other entitlements such as energy assistance, or public assistance. Assistance with identifying financial resources to assist with housing for the participant including special needs trusts and ABLE accounts

• Working with the Supports Coordinator and service plan team to identify needed assistive technology or home accessibility adaptations, which are necessary to ensure the participant's health and well-being.

• Assistance with coordinating the move from a congregate living arrangement or from a family home to a more independent setting; providing training on how to be a good tenant.

• Working collaboratively with other service providers and unpaid supports.

• Assistance with identifying resources to secure household furnishings and utility assistance. Activities will include identifying and coordinating resources that may assist with obtaining a security deposit, first month rent, or any other costs associated with the transition.

Financial support that constitutes a room and board expense is excluded from federal financial participation in the waiver.

This service is also available to support participants to maintain tenancy in a private home owned, rented or leased by the participant. The availability of ongoing housing-related services in addition to other long term services and supports promotes housing success, fosters community integration and inclusion, and develops natural support

networks. These tenancy support services are:

• Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.

• Education and training on the role, rights and responsibilities of the tenant and landlord.

• Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

• Assistance with activities such as supporting the participant in communicating with the landlord and/or property manager; developing or restoring interpersonal skills in order to develop relationships with landlords, neighbors and others to avoid eviction or other adverse lease actions; and supporting the participant in understanding the terms of a lease or mortgage agreement.

• Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized.

• Assistance with the housing recertification process.

• Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

• Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

This service can be delivered in Pennsylvania.

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

Housing Transition and Tenancy Sustaining services are limited to 640 (15-minute) units which is equal to 160 hours per participant per fiscal year.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Housing Transition and Tenancy Sustaining Provider |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Housing Transition and Tenancy Sustaining Service**

**Provider Category:**

Agency

**Provider Type:**

Housing Transition and Tenancy Sustaining Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania, Washington DC, Virginia or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance in accordance with state law.

7. Have knowledge of and how to access, refer to, and inform others on the following programs or resources, including, but not limited to:
- Housing choice vouchers.
- Section 811 PRA
- Mainstream/Non-Elderly Disabled (NED) vouchers.
- Project based operating assistance.
- Tenant based rental assistance (HOME and NHT).
- 20% Units (LIHTC deeply affordable/accessible units).
- Fair housing.
- Reasonable accommodations.
- Home ownership programs.
- USDA rural housing services, loans, and grants.
- Local and regional housing providers, housing resources and organizations serving persons with disabilities and older adults.
- Privately financed housing opportunities and any other project based subsidies, local-state-federal housing initiatives as they are available.
- Discharge processes from various institutional and residential settings.
- Home Modifications funded through the Department, PHFA, and DCED.
- Olmstead requirements.
- Housing First.
- Trained in Prepared Renters Program (PREP) training for agencies
- Ability to use PAHousingSearch.com

8. Comply with Department standards related to provider qualifications.

Staff working for or contracted with the agency as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

# 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:**

Music Therapy, Art Therapy and Equine Assisted Therapy

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 11 Other Health and Therapeutic Services | 11130 other therapies |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Direct therapy services provided to a participant who may or may not have a primary diagnosis of mental illness, but who could benefit by the provision of therapy to maintain, improve or prevent regression of the participant's condition and assist in the acquisition, retention or improvement of skills necessary for the participant to live and work in the community. Direct Music and Art Therapy services may be provided using remote technology in accordance with ODP policy. Services and intended benefit must be documented in the service plan. Therapy services consist of the following individual therapies that are not primarily recreational or diversionary:

- Art Therapy;
- Music Therapy; and
- Equine Assisted Therapy.

The initial session of Music Therapy, Art Therapy or Equine Assisted Therapy must include an assessment of the participant's need for the service. If additional sessions are indicated following the assessment of need, therapists providing these services must develop a treatment plan that reflects individualized, attainable goals to be achieved during the remaining sessions.

Music Therapy and Art Therapy can only be provided to adult participants (participants age 21 and older). All Music Therapy and Art Therapy for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Music Therapy and Art Therapy may only be funded for adult participants through the Waiver if documentation is secured by the Supports Coordinator that shows the service is medically necessary and either not covered by the participant's insurance, insurance limitations have been reached, or the service is not covered by Medical Assistance or Medicare or limitations for Medical Assistance or Medicare have been reached.

Equine Assisted Therapy can be provided to participants of any age as it is not covered by Medical Assistance. For school age participants, Supports Coordinators must document that Equine Assisted therapy is not covered through the participant's individualized education plan (IEP) or through the participant's insurance.

Music Therapy, Art Therapy and Equine Assisted Therapy may not be provided at the same time as the direct provision of the following: Community Participation Support; Small Group Employment; Supported Employment; Advanced Supported Employment; Benefits Counseling; 15-minute unit Respite; Transportation; Therapies; Education Support and Consultative Nutritional Services.

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

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

The cumulative maximum limit of any combination of Music Therapy, Art Therapy, or Equine Assisted Therapy is 104 (15-minute) units which is equal to 26 hours per participant per fiscal year.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Hippotherapist or Therapeutic Riding Instructor |
| Agency | Agency |
| Individual | Music Therapist |
| Individual | Art Therapist |

# Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Music Therapy, Art Therapy and Equine Assisted Therapy**

**Provider Category:**

Individual

**Provider Type:**

Hippotherapist or Therapeutic Riding Instructor

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

To provide Equine Assisted Therapy the individual must have one of the following certificates:
1. Certified by the American Hippotherapy Certification Board;

2. Certified by the Professional Association of Therapeutic Horsemanship (PATH) International;

3. Certified by the Pennsylvania Council on Therapeutic Horsemanship (PACTH); or

4. Other ODP-approved certification board.

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

To provide Equine Assisted Therapy the individual must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have criminal history clearances per 35 P.S. 10225.101 et seq. and 6 Pa. Code Chapter 15.

7. Have child abuse clearance (when the participant is under age 18) as per 23 Pa. C.S. Chapter 63.

8. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

# Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Music Therapy, Art Therapy and Equine Assisted Therapy**

**Provider Category:**

Agency

**Provider Type:**

Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

To provide Music Therapy, staff must have one of the following certificates:
1. Certified by the Certification Board for Music Therapists (CBMT), or

2. Other ODP-approved certification board.

To provide Art Therapy, staff must have one of the following certificates:
1. Certified by the Art Therapy Credentials Board (ATCB); or

2. Other ODP-approved certification board.

To provide Equine Assisted Therapy, staff must have one of the following certificates:
1. Certified by the American Hippotherapy Certification Board;

2. Certified by the Professional Association of Therapeutic Horsemanship (PATH) International;

3. Certified by the Pennsylvania Council on Therapeutic Horsemanship (PACTH); or

4. Other ODP-approved certification board.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance, in accordance with state law.

7. Comply with Department standards related to provider qualifications.

Staff working for or contracted with the agency must meet the following standards:
1. Complete necessary pre/in-service training based on the service plan.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Music Therapy, Art Therapy and Equine Assisted Therapy**

**Provider Category:**

Individual

**Provider Type:**

Music Therapist

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

To provide Music Therapy the individual must have one of the following certificates:
1. Certified by the Certification Board for Music Therapists (CBMT), or

2. Other ODP-approved certification board.

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

To provide Music Therapy the individual must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have criminal history clearances per 35 P.S. 10225.101 et seq. and 6 Pa. Code Chapter 15.

7. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

8. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Music Therapy, Art Therapy and Equine Assisted Therapy**

**Provider Category:**

Individual

**Provider Type:**

Art Therapist

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

To provide Art Therapy the individual must have one of the following certificates:
1. Certified by the Art Therapy Credentials Board (ATCB); or

2. Other ODP-approved certification board.

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

To provide Art Therapy the individual must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have criminal history clearances per 35 P.S. 10225.101 et seq. and 6 Pa. Code Chapter 15.

5. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

6. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

# Appendix C: Participant Services

## C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Participant-Directed Goods and Services

**HCBS Taxonomy:**

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

| | |
|---|---|
| 17 Other Services | 17010 goods and services |

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

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

**Service Definition** *(Scope):*

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

Participant-Directed Goods and Services are services, equipment or supplies not otherwise provided through other services offered in this waiver, the Medicaid State Plan, or a responsible third-party. Participant-Directed Goods and Services must address an identified need in the participant's service plan and must achieve one or more of the following objectives:

- Decrease the need for other Medicaid services.
- Promote or maintain inclusion in the community.
- Promote the independence of the participant.
- Increase the participant's health and safety in the home environment.
- Develop or maintain personal, social, physical or work-related skills.
- Items and services must be used primarily for the benefit of the participant.

Participant-directed Goods and Services may not be used for any of the following:

- Personal items and services not related to the participant's intellectual disability or autism;
- Experimental or prohibited treatments;
- Entertainment activities, including vacation expenses, lottery tickets, alcoholic beverages, tobacco/nicotine products, movie tickets, televisions and related equipment, and other items as determined by the Department; or
- Expenses related to routine daily living, including groceries, rent or mortgage payments, utility payments, home maintenance, gifts, pets (excluding service animals), and other items as determined by the Department.
- Items and services that are excluded from receiving Federal Financial Participation, including but not limited to room and board payments which include the purchase of furnishings and services provided while a participant is an inpatient of a hospital, nursing facility, or ICF/ID.

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

Participant-directed Goods and Services are limited to $2,000 per participant per fiscal year.

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

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Vendor Fiscal/Employer Agent Financial Management Services |
| Agency | Agency with Choice |

## Appendix C: Participant Services

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

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

**Provider Category:**

Agency

**Provider Type:**

Vendor Fiscal/Employer Agent Financial Management Services

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

The Vendor Fiscal/Employer Agent Financial Management Services must comply with all requirements specified in the current contract between the Vendor Fiscal/ Employer Agent and the Pennsylvania Department of Human Services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Pennsylvania Department of Human Services

**Frequency of Verification:**

Frequency as specified in the current contract between the Vendor Fiscal/Employer Agent and the Pennsylvania Department of Human Services.

## Appendix C: Participant Services

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

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

**Provider Category:**

Agency

**Provider Type:**

Agency with Choice

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

The Agency with Choice must comply with all requirements specified in regulations and bulletins relating to Agency with Choice operations.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Developmental Programs

**Frequency of Verification:**

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

## 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:**

Shift Nursing

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 05 Nursing | 05010 private duty nursing |
| **Category 2:** | **Sub-Category 2:** |
| 05 Nursing | 05020 skilled nursing |

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

**Service Definition** *(Scope):*

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

Shift Nursing is a direct service that can be provided either part-time or full-time in accordance with 49 Pa. Code Chapter 21 (State Board of Nursing) which provides the following service definition for the practice of professional nursing:

"Diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The term does not include acts of medical diagnosis or prescription of medical, therapeutic or corrective measures, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the Board, which rules and regulations will be implemented by the Board."

Shift Nursing for adult participants (participants age 21 and older) is generally not available through Medical Assistance Fee-For-Service or Physical Health Managed Care Organizations. Home health care, which is defined as a rehabilitative nursing component, is the only service available in the participant's home through Medical Assistance.

Shift Nursing services can only be provided to adult participants. All medically necessary Shift Nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Shift Nursing services may only be funded for adult participants through the Waiver if documentation is secured by the Supports Coordinator that shows the service is medically necessary and either not covered by the participant's insurance or insurance limitations have been reached. A participant's insurance includes Medical Assistance (MA), Medicare and/or private insurance.

This service may be provided at the following levels:

- Basic - Staff-to-individual ratio of 1:2.
- Level 1 – Staff-to-individual ratio of 1:1.

Effective starting 7/1/17, participants authorized to receive Shift Nursing services may not receive the following services at the same time as this service: Respite (15-minute unit and Day); Companion; In-Home And Community Supports; Community Participation Support; Transitional Work; Supported Employment; Advanced Supported Employment; Benefits Counseling; Therapies; and Consultative Nutritional Services.

Starting 7/1/17, participants authorized to receive Shift Nursing services may not be authorized to receive Supported Living during the same time period.

Starting 1/1/18, participants authorized to receive Shift Nursing services may not be authorized to receive Residential Habilitation or Life Sharing during the same time period.

Shift Nursing can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania and other locations as per the ODP travel policy.

**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 | Nurse |
| Agency | Nursing Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Shift Nursing**

**Provider Category:**

Individual

**Provider Type:**

Nurse

**Provider Qualifications**

**License** *(specify):*

Individual nurses must meet the following requirements:
• Be a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

• Comply with Title 49 Pa. Code Chapter 21.

• Nurses with a waiver service location in a state contiguous to Pennsylvania must comply with regulations comparable to Title 49 Pa. Code Chapter 21.

**Certificate** *(specify):*

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

Nurses must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

6. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

7. Have Workers' Compensation Insurance, in accordance with state statute.

8. Be trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

9. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Shift Nursing**

**Provider Category:**

Agency

**Provider Type:**

Nursing Agency

**Provider Qualifications**

**License** *(specify):*

Staff (direct, contracted, or in a consulting capacity) providing Shift Nursing services must be a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

Providers with a waiver service location in Pennsylvania must comply with Title 49 Pa. Code Chapter 21.

Providers with a waiver service location in a state contiguous to Pennsylvania must comply with regulations comparable to Title 49 Pa. Code Chapter 21.

**Certificate** *(specify):*

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance, in accordance with state law.

7. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

Nurses working for or contracting with agencies must meet the following standards:
1. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

2. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Small Group Employment

**HCBS Taxonomy:**

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

**Service Definition** *(Scope):*

Small Group Employment services are direct services that consist of supporting participants in transitioning to competitive integrated employment through work that occurs in a location other than a facility subject to 55 Pa. Code Chapter 2380 or Chapter 2390 regulations such as an integrated industry, business, or community setting. The goal of Small Group Employment services is acquisition of knowledge, skills and experiences that lead to competitive integrated employment, including self-employment. Participants receiving this service must have a competitive integrated employment outcome included in their service plan, and it must be documented in the service plan how and when the provision of this service is expected to lead to competitive integrated employment. Work that participants perform during the provision of Transitional Work services must be paid at least minimum wage and the compensation must be similar to compensation earned by workers without disabilities performing the same work.

Small Group Employment service options include mobile work force, work station in industry, affirmative industry, and enclave. Each of these options are delivered in integrated business, industry or community settings that do not isolate participants from others in the setting who do not have disabilities. Services must be provided in a manner that promotes engagement in the workplace and interaction between participants and people without disabilities including co-workers, supervisors, and customers, if applicable. Small Group Employment services are only billable when the participant is receiving direct support during the time that he or she is working and receiving wages through one of these service options or during transportation to a work site.

A Mobile Work Force uses teams of individuals, supervised by a training/job supervisor, who conduct service activities at a location 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 participants 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 participant(s) demonstrates job expertise and meets 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 with disabilities 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. Supervisory personnel and staff of providers who are paid to render the Small Group Employment service cannot be counted in the percentage of employees who do not have a disability.

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

The service also includes transportation that is an integral component of the service; for example, transportation to a work site. The Small Group Employment provider is not, however, responsible for transportation to and from a participant’s home, unless the provider is designated as the transportation provider in the participant’s service plan. In this case, the transportation service must be authorized and billed as a discrete service.

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

This service may be provided at the following levels:

- Basic - Staff-to-individual ratio of 1:10 to 1:6.
- Level 1 - Staff-to-individual ratio range of <1:6 to 1:3.5.
- Level 2 - Staff-to-individual ratio range of <1:3.5 to >1:1.
- Level 3 - Staff-to-individual ratio of 1:1.

Small Group Employment services may not be rendered under the Waiver until it has been verified that the service is not available in the student’s (if applicable) complete and approved Individualized Education Program (IEP) developed pursuant to IDEA. Documentation must be maintained in the file of each participant receiving Small

Group Employment services to satisfy this state assurance.

Small Group Employment services may be provided without referring a participant to OVR as OVR does not provide Small Group Employment services.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment services; or
2. Payments that are passed through to users of small group employment services.

Participants authorized to receive Small Group Employment services may not receive the direct portion of the following services at the same time: In-Home and Community Supports; Companion; Community Participation Support; 15-minute unit Respite; Supported Employment; job acquisition and job retention in Advanced Supported Employment; Benefits Counseling; Transportation; Therapies; Education Support; Music, Art and Equine Assisted Therapy and Consultative Nutritional services.

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

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

When Small Group Employment services are not provided with any other employment service (Supported Employment, Advanced Supported Employment and/or Community Participation Support) the hours of authorized Small Group Employment cannot exceed 40 hours (160 15-minute units) per participant per calendar week.

When Small Group Employment services are provided in conjunction with Supported Employment and/or Community Participation Support the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 50 hours (200 15-minute units) per participant per calendar week.

**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 | Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Small Group Employment**

**Provider Category:**

Agency

**Provider Type:**

Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Staff working directly with the participant to provide Small Group Employment services must have one of the following by 7/1/19 or within six months of hire if hired after 1/1/19:
• Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE); or

• Have been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.

Effective 7/1/19, newly hired staff who do not have the required certification when hired must work under the supervision of someone who is certified. This can occur no longer than six months from the date of hire to allow the new staff time to obtain the certification.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of Small Group Employment have automobile insurance

7. Have documentation that all vehicles used in the provision of Small Group Employment have current State motor vehicle registration and inspection.

8. Have Workers' Compensation Insurance, in accordance with state law.

9. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

10. Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Complete necessary pre/in-service training based on the service plan.

3. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

4. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

5. Have a valid driver's license if the operation of a vehicle is necessary to provide Transitional Work services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

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

**Service Type:**

Other Service

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

**Service Title:**

Transportation

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 15 Non-Medical Transportation | 15010 non-medical transportation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

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

Transportation services consist of:
1. Transportation (Mile). This transportation service is delivered by providers, family members, and other licensed drivers. Transportation Mile is used to reimburse the owner of the vehicle or other qualified licensed driver who transports the participant to and from services, competitive integrated employment, and resources specified in the participant's service. The unit of service is one mile. Mileage will be paid per trip. A trip is defined as from the point of pick-up to the destination while the participant is in the car as identified in the service plan. When transportation is provided to more than one participant at a time, the provider will divide the shared miles equitably among the participants to whom transportation is provided. The provider is required (or it is the legal employer's responsibility under the VF/EA model) to track mileage, allocate a portion to each participant and provide that information to the Supports Coordinator for inclusion in the participant's service plan. This will be monitored through routine provider monitoring activities.

2. Public Transportation. Public transportation services are outcome-based vendor services provided to or purchased for participants to enable them to gain access to services and resources specified in their service plans. The utilization of public transportation promotes self-determination and is made available to participants as a cost-effective means of accessing services and activities. Public transportation may be purchased by an OHCDS for participants who do not self-direct or Financial Management Service Organizations for participants who are self-directing when the public transportation vendor does not elect to enroll directly with ODP. Public transportation purchased for a participant may be provided to the participant on an outcome basis.

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

Effective until June 30, 2019, zones are defined as the following:
- Zone 1 - Greater than 0 and up to 20 miles.
- Zone 2 - Greater than 20 miles and up to 40 miles.
- Zone 3 - Greater than 40 and up to 60 miles.

Effective July 1, 2019, zones are defined as the following:
- Zone 1 - Greater than 0 and up to 10 miles.
- Zone 2 - Greater than 10 miles and up to 30 miles.
- Zone 3 - Greater than 30 miles.

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

For participants under the age of 21, Transportation services may only be used to travel to and from waiver services or a job that meets the definition of competitive integrated employment.

Participants authorized to receive Transportation services may not receive the direct portion of the following services at the same time: Community Participation Support; Small Group Employment; Supported Employment; job acquisition and job retention in Advanced Supported Employment; Benefits Counseling; Therapies; Education Support; Music, Art and Equine Assisted Therapy; and Consultative Nutritional services.

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

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

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

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual |
| Individual | Support Service Professional |
| Agency | Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**

Individual

**Provider Type:**

Individual

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

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

Individual providers must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Complete standard ODP required orientation and training.

3. Have a signed ODP Provider Agreement on file with ODP.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Be at least 18 years of age.

6. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

7. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

8. Have documentation that all vehicles used in the provision of Transportation services have automobile insurance.

9. Have a valid driver's license.

10. Have documentation that all vehicles used in the provision of Transportation services have current State motor vehicle registration and inspection.

11. Have Workers' Compensation Insurance, in accordance with state law.

12. Be trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

13. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OHCDS for public transportation and transportation mile.

ODP or its Designee for all types of transportation rendered by individual providers that enroll directly with the Department.

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**

Individual

**Provider Type:**

Support Service Professional

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Support Service Professionals must meet the following standards:
1. Be at least 18 years of age.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

4. Have documentation that all vehicles used in the provision of Transportation services have automobile insurance

5. Have a valid driver's license.

6. Have documentation that all vehicles used in the provision of Transportation services have current State motor vehicle registration and inspection.

7. Be trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

8. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC or VF/EA FMS for transportation mile.

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**

Agency

**Provider Type:**

Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Agencies must have PUC Certification, when required by state law or comparable certificate in contiguous states.

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures. Public transportation providers are exempt from this requirement.

5. Have Commercial General Liability Insurance.

6. Have documentation that all vehicles used in the provision of Transportation services have automobile insurance.

7. Have documentation that all vehicles used in the provision of Transportation services have current State motor vehicle registration and inspection.

8. Have Workers' Compensation Insurance, in accordance with state law.

9. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

10. Comply with Department standards related to provider qualifications.

Drivers and aides working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.

2. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

4. Have a valid driver's license if the operation of a vehicle is necessary to provide Transportation services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OHCDS, VF/EA FMS or AWC FMS for public transportation.

OHCDS for transportation mile.

ODP or its Designee for all types of transportation rendered by agency providers that enroll directly with the Department.

**Frequency of Verification:**

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

## 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 Accessibility Adaptations

**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 accessibility adaptations consist of certain modifications to the vehicle that the participant uses as his or her primary means of transportation to meet his or her needs. The modifications must be necessary due to the participant's disability. The vehicle that is adapted 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 of services.

Vehicle accessibility adaptations consist of installation, repair, maintenance, and extended warranties for the modifications.
Regularly scheduled upkeep and maintenance of the vehicle, including warranties that cover the entire vehicle, except for upkeep and maintenance of the modifications, is excluded.

The waiver cannot be used to purchase vehicles for participants, their families or legal guardians; however, this service can be used to fund the portion of a new or used vehicle purchase that relates to the cost of accessibility adaptations. In order to fund these types of adaptations, a clear breakdown of purchase price versus adaptation is required.

These adaptations funded through the Waiver are limited to the following:

- 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.
- Raising the roof or lowering the floor to accommodate wheelchairs.

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

This service is limited to $20,000 per participant during a 10-year period. The 10-year period begins with the first utilization of authorized Vehicle Accessibility Adaptations.

**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 | Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Vehicle Accessibility Adaptations**

**Provider Category:**
Agency
**Provider Type:**

Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Agencies must meet the following standards:
1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2. Have a signed ODP Provider Agreement on file with ODP.

3. Complete standard ODP required orientation and training.

4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.

5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance in accordance with state law.

7. Comply with Department standards related to provider qualifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

AWC FMS, VF/EA FMS, OHCDS, ODP or its Designee

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

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

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

  *Check each that applies:*

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

*C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

## Appendix C: Participant Services

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

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

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

◉ **Yes. Criminal history and/or background investigations are required.**

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

The Office of Developmental Programs (ODP) requires background clearances for all staff and volunteers who serve waiver participants. There are differences in the background clearance requirements depending on the role of the person working with participants (staff versus volunteer) and the age of the participant (a child under 18 years of age or an adult 18 years of age and older. Listed first are the requirements for staff and volunteers serving adults followed by the requirements for staff and volunteers children.

ODP requires criminal background checks for all staff (which includes contractors or consultants) and volunteers who provide a waiver service through direct contact with an adult participant or are responsible for the provision of the service for an adult participant.

A Volunteer is defined as a person who:

1. Provides one or more direct waiver services to a participant as authorized in the service plan,

2. Has unsupervised contact with the participant when providing the service(s), i.e. is alone with the participant,

3. Has freely chosen not to receive monetary compensation for provision of the service(s), and

4. Provides the service(s) on behalf of a qualified provider that has been authorized in a service plan to receive reimbursement for the service(s).

Specific requirements for criminal background checks are included in 35 P.S. §10225.101 et seq., 6 Pa. Code Chapter 15 (Older Adult Protective Services Act, OAPSA) and 55 Pa. Code Chapter 51 or its regulatory successor. OAPSA and 55 Pa. Code Chapter 51 require that criminal background checks are requested from the Pennsylvania State Police prior to the applicant's date of hire. If the applicant has not been a resident of the Commonwealth for the two years immediately preceding the date of application, a report of Federal criminal history record must be requested from the Federal Bureau of Investigation (FBI) in addition to a criminal history record from the Pennsylvania State Police.

***Requirements for staff who are responsible for the welfare of or have direct contact children.***

Before beginning employment, staff who are either “responsible for the welfare of” or have “direct contact with a child” must obtain a report of criminal history from the Pennsylvania State Police, fingerprint based federal criminal history submitted through the Pennsylvania State Police or its authorized agent (FBI), and a Child Abuse History Certification from the Department of Human Services (Child Abuse). Staff are also required to renew these certifications every 60 months. For further specific requirements regarding staff please refer to 23 Pa C.S. §§ 6303, 6344, and 6344.4.

A person responsible for the child's welfare is a person who provides permanent or temporary care, supervision, mental health diagnosis or treatment, training or control of a child in lieu of parental care, supervision and control. Direct contact with children is providing care, supervision, guidance or control of children or having routine interaction with children. Routine interaction with children is regular and repeated contact with children that is integral to his or her employment responsibilities.

An agency may provisionally hire a staff person pending the receipt of the background certifications as required under 23 Pa C.S. § 6344 (m). Persons responsible for employment decisions may employ applicants on a provisional basis for up to 90 days, if the following conditions are met:

1. The applicant has applied for the required certifications and provides copies of the request forms to the employer.

2. The employer has no knowledge of information regarding the applicant that would disqualify him pursuant to 23 Pa C.S. § 6344 (c) (grounds for denying employment or participation in program, activity, or service).

3. The applicant swears in writing he is not disqualified pursuant to 23 Pa C.S. § 6344 (c) (grounds for denying employment or participation in program, activity, or service).

4. If information obtained as a result of the certification requires disqualification of the applicant, the employer will

immediately dismiss the applicant.

5. During provisional employment, the applicant is not permitted to work alone with children and must work in the immediate vicinity of a permanent staff person.

***Requirements for volunteers who are responsible for the welfare of or have direct volunteer contact with children.***

Before beginning service, adult volunteers who are either responsible for the child's welfare or have direct volunteer contact with a child must obtain a report of criminal history from the Pennsylvania State Police and a child abuse history certification from the Department of Human Services (Child Abuse). A volunteer is relieved of the requirement to obtain the fingerprint based federal criminal history submitted through the Pennsylvania State Police or its authorized agent (FBI) if:

1. The position the volunteer is applying for is unpaid.

2. The volunteer has been a resident of Pennsylvania for the entirety of the previous ten-years.

3. The volunteer swears in writing that they are not disqualified from service as required under 23 Pa C.S. § 6344 (c) (grounds for denying employment or participation in program, activity, or service).

If a volunteer has not been a resident of Pennsylvania for the past 10 years, but obtained their FBI certification at any time since establishing residency, they must provide a copy of the certification to the person responsible for the selection of volunteers and they are not required to obtain any additional FBI certifications. Non-resident volunteers who have residency in another state or country may begin serving provisionally not to exceed a total of 30 days in a calendar year if the volunteer is in compliance with the certification standards under the law or jurisdiction where they reside. The nonresident volunteer must provide documentation of certifications. For specific requirements please see 23 Pa C.S. § 6344.2 (f). Volunteers are also required to renew these certifications every 60 months. For further specific requirements regarding volunteers please refer to 23 Pa C.S. §§ 6303, 6344, 6344.2, and 6344.4.

Compliance with background check requirements is verified through initial and ongoing provider qualification reviews, as well as provider monitoring conducted by ODP or the ODP Designee. For licensed providers, compliance with the Pennsylvania Code is also verified through annual licensing inspections.

**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 | |
|---|---|
| Community Homes | |

**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 in the response contained in appendix C-5.

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Community Homes

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| Participant-Directed Goods and Services | ☐ |
| Behavioral Support | ☐ |
| Therapy Services | ☐ |
| Music Therapy, Art Therapy and Equine Assisted Therapy | ☐ |
| Specialized Supplies | ☐ |
| Advanced Supported Employment | ☐ |
| Community Participation Support | ☐ |
| Companion | ☐ |
| Benefits Counseling | ☐ |
| Respite | ☐ |
| Small Group Employment | ☐ |
| Supported Employment | ☐ |
| Supports Broker Services | ☐ |
| Assistive Technology | ☐ |
| Family/Caregiver Training and Support | ☐ |

| Waiver Service | Provided in Facility |
|---|---|
| **Transportation** | ☐ |
| **Consultative Nutritional Services** | ☐ |
| **In-Home and Community Support** | ☐ |
| **Family Medical Support Assistance** | ☐ |
| **Family Medical Support Assistance** | ☐ |
| **Shift Nursing** | ☐ |
| **Communication Specialist Services** | ☐ |
| **Supports Coordination** | ☐ |
| **Vehicle Accessibility Adaptations** | ☐ |
| **Home Accessibility Adaptations** | ☐ |
| **Homemaker/Chore** | ☐ |
| **Housing Transition and Tenancy Sustaining Service** | ☐ |
| **Education Support Services** | ☐ |

**Facility Capacity Limit:**

8

**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:**

With publication of final regulations and the addition of the new section Appendix C-5 regarding home and community-based setting requirements, this section of the waiver application is no longer needed. Therefore,
states should not complete this section C-2- c, and all instructions and technical guidance for this section of the application have been removed from this version of the Technical Guide that includes changes implemented in 2014. States with existing approved 1915(c) waivers will need to complete the new section C-5 upon renewal or amendment. Eventually, once all existing waivers have the new section C-5 incorporated into their approved existing waivers, CMS will delete this section from the waiver application. In the interim, if a waiver provides services in residential facilities serving four or more unrelated individuals, states should only enter in the text box following Appendix C-2- c-ii: "Required information is contained in response to C-5" and complete Appendix C-5 for all settings that meet the HCB settings requirements.

## 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.*

The only waiver service legally responsible individuals can provide that has personal care components is In-Home and Community Support. A legally responsible individual is a person who has legal obligation under the provisions of law to care for another person, including parents of minor children (under the age of 18) and legally-assigned relative caregivers of minor children. These individuals may be paid to provide In-Home and Community Support services when the following conditions are met:

• The service is considered extraordinary care. A parent is legally responsible to meet the needs of a minor child, including the need for assistance and supervision typically required for children at various stages of growth and development. A parent can, however, receive payment for In-Home and Community Support when this support goes beyond what would be expected to be performed in the usual course of parenting, and when needed support exceeds what is typically required for a child of the same age;

• The service would otherwise need to be provided by a qualified provider of services funded under the Waiver;

• The legally responsible individual is not the common law employer or managing employer for the participant that they will provide the service to;
• The service is provided by a legally responsible individual who meets the qualification criteria that are established by ODP in Appendix C-3 of the approved Waivers.

The service definition for In-Home and Community Support outlines limits for the number of hours that legally responsible individuals, relatives or legal guardians may provide the service.

Payments to legally responsible individuals who provide services are made through a Financial Management Services (FMS) Organization or a provider agency. Payments are based upon time sheets submitted by the legally responsible individual to the FMS or agency, which is consistent with the participant's authorized services on their service plan. The ODP designee is responsible to ensure that payments are only made for services that are authorized on the participant's approved service plan. The legally responsible individual who provides services must document service delivery per Department standards, 55 Pa. Code Chapter 1101 (Medical Assistance Regulations) and ODP policy requirements.

☒ **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.*

◉ **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.

Relatives and legal guardians may be paid to provide services funded through the Waiver on a service-by-service basis. A relative is any of the following by blood, marriage or adoption who have not been assigned as legal guardian for the participant: a spouse, a parent of an adult, a stepparent of an adult child, grandparent, brother, sister, aunt, uncle, niece, nephew, adult child or stepchild of a participant or adult grandchild of a participant. For the purposes of this policy, a legal guardian is a person who has legal standing to make decisions on behalf of a minor or adult (e.g. a guardian who has been appointed by the court). The definition of a legal guardian does not apply to agency providers, but does apply to the person actually rendering service to a participant. These individuals may be paid to provide Waiver services when the following conditions are met:

• The individual has expressed a preference to have the relative or legal guardian provide the service(s);

• The service provided is not a function that the relative or legal guardian would normally provide for the participant without charge in the usual relationship among members of a nuclear family;

• The service would otherwise need to be provided by a qualified provider of services funded under the Waiver;

• The relative or legal guardian is not the common law employer or managing employer for the participant that they will provide services to. The only service a common law employer or managing employer may receive payment for is Transportation (Mile); and

• The service is provided by a relative or legal guardian who meets the qualification criteria that are established by ODP in Appendix C-3 of the approved Waiver.

Services that relatives or legal guardians can provide are limited to the following: In-Home and Community Support, Companion, Life Sharing, Supported Employment, Nursing and Transportation (Mile). Relatives and legal guardians who are not the participant's primary caregiver may also provide Supports Broker Services and Respite Services when the conditions listed above are met.

The service definitions for In-Home and Community Support and Companion outlines limits for the number of hours that legally responsible individuals, relatives or legal guardians may provide each service or a combination of both services when authorized on the service plan.

Legally responsible individuals as defined in appendix C-2-d may also provide the following services that do not have a personal care component:

• Supported Employment; and

• Transportation Mile solely to drive a minor child to and from a waiver service or a job that meets the definition of competitive integrated employment.

Payments to relatives, legal guardians and legally responsible individuals who provide services are made through a Financial Management Services (FMS) Organization, or a provider agency. Payments are based upon time sheets submitted by the relative, legal guardian or legally responsible individual to the FMS or agency, which is consistent with the participant's authorized services on his or her service plan. The relative, legal guardian or legally responsible individual who provides services must document service delivery per Department standards and ODP policy requirements. Documentation of service delivery is reviewed during the provider monitoring process.

During the service plan team meeting, the team is responsible for discussing whether having services furnished by relatives, legal guardians or legally responsible individuals is in the best interest of the participant. The decision should be consistent with the information contained in the “know and do”, “important to” and “what makes sense” sections of the service plan. The Administrative Entity, when reviewing and authorizing the service plan, is responsible for ensuring that the participant has been offered a choice of providers and that the provider chosen can meet the needs of the participant.

○ **Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All willing and qualified providers have the opportunity to enroll as Waiver providers at any time. ODP has continuous open enrollment of providers and does not limit the application for provider enrollment to a specific timeframe. Providers must enroll with Pennsylvania's Medicaid program prior to providing waiver services, and may obtain information about doing so at http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

Providers interested in providing ODP Waiver services contact the AE or ODP to obtain information on provider qualification and enrollment. Providers may also be referred by participants. Providers may also access enrollment information at https://www.hcsis.state.pa.us/hcsis-ssd/default.aspx and the ODP website, www.myodp.org.

ODP requires providers who have expressed an interest in providing Waiver services to successfully complete a free "new provider orientation training" before they can be enrolled as Waiver providers. The intent of applicant orientation is to ensure providers are informed of ODP ID Waiver requirements and ODP's expectations regarding the quality of services.

Following completion of the new provider orientation training, the provider completes and submits a Waiver provider agreement in which the provider agrees to render services in accordance with state and federal requirements. A copy of the Waiver provider agreement can be obtained at https://www.hcsis.state.pa.us/hcsis-ssd/custom/OMR_MAProviderAgreement.pdf.

The provider must then be qualified by ODP or its designee as per the qualification criteria outlined in Appendix C-1/C-3 and the ODP established provider qualification process. Following successful qualification, the provider enrolls as an ODP provider in PROMISe, Pennsylvania's Medicaid Management Information System. Upon enrollment in PROMISe, the provider's information is added to ODP's Services and Supports Directory at https://www.hcsis.state.pa.us/hcsis-ssd/pgm/asp/prhom.asp.

ODP also has a dedicated email (ra-odpproviderenroll@pa.gov) for questions or concerns related to the new provider orientation training, the provider qualification process, or general inquiries related to enrollment and the enrollment process.

Any provider who is denied the opportunity to enroll to provide Waiver services has the right to appeal such action in accordance with 55 Pa. Code Chapter 41 relating to Medical Assistance Provider Appeal procedures.
Waiver participants have free choice of willing and qualified Waiver providers to provide needed services in the participant's approved service plan.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

**a. Methods for Discovery: Qualified Providers**

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

**i. Sub-Assurances:**

**a.** ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or***

***certification standards and adhere to other standards prior to their furnishing waiver services.***

**Performance Measures**

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

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

**Performance Measure:**
**QP1 - Number and percent of providers that initially and continually meet required licensure and/or certification standards and adhere to other state standards.**
**Numerator = number of providers that initially and continually meet required licensure and/or certification standards and adhere to other state standards.**
**Denominator = all providers that require licensure and/or certification.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**ODP Enrollment Spreadsheet; 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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:**
**QP2 - Number and percent of non-licensed, non-certified providers that meet waiver requirements. Numerator = number of non-licensed, non-certified providers that meet waiver requirements. Denominator = all non-licensed, non-certified providers. (Includes OHCDS and AWC providers.)**

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

If 'Other' is selected, specify:
**ODP Enrollment Spreadsheet; 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**
**QP3 - Number and percent of providers delivering Participant Directed Services that meet requirements. Numerator = number of providers delivering Participant Directed Services that meet requirements. Denominator = providers delivering Participant Directed Services. (Includes VF Support Service Professionals (SSPs).**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Enrollment Unit Database; Vendor Fiscal Contractor 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and** | ☐ **Other** |

| | | |
|---|---|---|
| | **Ongoing** | Specify: |
| | ☒ **Other**<br>Specify:<br>Biannually | |

**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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☒ **Other**<br>Specify:<br>Biannually |

**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:**
**QP4 - Number and percent of providers that meet training requirements in accordance with state requirements in the approved waiver. Numerator = number of providers that meet training requirements in accordance with state requirements in the approved waiver. Denominator = Number of providers reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA&I Process 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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.

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The Department conducts licensing activities initially and continually for licensed residential settings, licensed adult training facilities and licensed vocational facilities.

QP3. For initial qualification, the materials required for SSP enrollment set forth in 55 Pa. Code Chapter 51 are received and reviewed by the Vendor Fiscal/Employer Agent FMS organization in accordance with their contract.

• If the SSP is qualified, the FMS organization will enroll them.
• If the SSP is not qualified, the FMS organization will deny their enrollment.

On October 1st, using a 3-year cycle, ODP initiates the requalification of all providers. ODP works through its Vendor Fiscal Contractor to send a requalification packet to the Common Law Employer (CLE) for the number of Support Service Professionals (SSPs) the CLE has to requalify. The due date for requalification is October 31st, which is 60 days prior to the expiration date of December 31st. During the 60 days, the Central Office lead receives a weekly report from the Vendor Fiscal Contractor of the number SSPs that have not submitted their requalification information. During the 60 days, ODP also sends weekly reports to ODP Regional Offices, who in turn work with Administrative Entities and Supports Coordination Organizations in contacting CLEs providing Participant Directed Services and getting SSPs who will continue to offer services requalified. In addition, the Vendor Fiscal Contractor also notifies the CLE with phone calls, reminding the CLE of the expiration date and to ensure their SSPs requalify.

QP4. The Department (ODP or AEs) conducts on-site reviews through ODP's QA&I Process on a 3-year cycle for SCOs, providers (with the exception of public transportation providers) and AEs.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

---

QP1. Number and percent of providers that initially and continually meet required licensure and/or certification standards and adhere to other state standards. New providers who are presented for enrollment into PROMISe to deliver services to waiver participants are required to meet initial qualification requirements. The qualification of providers is the responsibility of the AEs. Providers that do not meet initial qualification requirements are denied by the AE and those providers are not enrolled into the PROMISe™ claims processing system, cannot be authorized to deliver services in a service plan, and cannot receive payment for services.

On an annual basis, ODP generates and distributes to AEs, a list of providers for whom they are designated to be the assigned AE. The AE is responsible to review the list and direct the requalification of providers. Providers are expected to provide documentation to AEs indicating that they have maintained required licensure and/or certification standards, and adhered to other applicable state standards at the required frequency. Each provider's specialty qualification expiration date is recorded and tracked electronically. Any provider not meeting the requalification requirement is disenrolled from PROMISe and can no longer be authorized or receive payment for services.

Providers denied initial or requalification receive written notice of the decision, indicating which requirements have not been met along with information regarding their right to initiate the appeal process as specified in 55 Pa. Code Chapter 41. Providers may resubmit an application for consideration along with additional documentation that such requirements have been met.

On the expiration date, should the provider fail to submit qualification documentation, the provider will become not qualified to provide the expired specialty. ODP will send a letter to the provider informing them that they are not qualified to provide the specialty under the waiver, that any expired specialties provided after the expiration date are ineligible for reimbursement through the waiver and that they have the right to request a fair hearing through the Department. Should the provider desire to provide the specialty through the waiver in the future, they may reenroll for the specialty as long as they meet qualifications.

If a fair hearing decision overturns a qualification decision, the provider will be re-enrolled into PROMISe to resume service delivery. ODP will complete enrollment action within 30 days of notification of fair hearing decision.

QP2. Number and percent of non-licensed, non-certified providers that meet waiver requirements. New provider qualification applications are reviewed by ODP or AEs. Provider applications that do not meet requirements are denied by ODP or the AE and those providers are not enrolled in the PROMISe™ claims processing system, cannot be authorized to deliver services in a service plan, and cannot receive payment for services. Providers denied qualification will receive written notice of the decision, indicating which requirements have not been met along with information regarding their right to initiate the appeal process as specified in 55 Pa. Code Chapter 41. Providers may resubmit an application for consideration along with additional documentation that such requirements have been met.

Current providers are expected to provide documentation to ODP or AEs indicating that they meet requirements at the required frequency. Each provider's specialty qualification expiration date is recorded and tracked electronically. Prior to a provider's qualification expiration date, the AE and the provider receive alerts notifying them of the provider's impending expiration. ODP or AEs are expected to notify the provider and ascertain whether there are impediments to providing qualification documentation by the qualification expiration date and provide assistance as needed. ODP sends an advance notice to the provider at least 30 days prior to their qualification expiration date informing them that failure to submit required qualification documentation by the expiration date will result in the provider becoming not qualified to provide the expired specialty and any expired specialty provided after the expiration date will be ineligible for reimbursement through the waiver. This notice will also inform providers that participants receiving the expiring specialty will start being transitioned to the participant's choice of willing and qualified providers and inform providers of their right to request a fair hearing through the Department. ODP and the responsible AE(s) will then begin activities to transition participants from providers who have expiring specialties to the participant's choice of willing and qualified providers. On the expiration date, should the provider fail to submit qualification documentation, ODP will not qualify the provider to provide the expired specialty. ODP will send a letter to the provider informing them that they are not qualified to provide the specialty under the Waiver, that any expired specialties provided after the expiration date are

ineligible for reimbursement through the waiver and that they have the right to appeal as specified in 55 Pa. Code Chapter 41. Should the provider desire to provide the specialty through the Waiver in the future, they may reenroll for the specialty as long as they meet qualifications.

Remediation strategies for QP3 and QP4 can be found in the Main Module Section B entitled Additional Information Needed (Optional).

**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.*

A $33,000 per person per fiscal year total limit is established for all P/FDS Waiver services with the following exceptions:

• Supports Coordination and Supports Broker services will be excluded from the limit because they are integral to ensuring the success of participants in utilizing traditional service models and participant directed service models.

• The limit can be exceeded by $15,000 for Advanced Supported Employment or Supported Employment services that are authorized on a participant's service plan.

• Individual cap exceptions for individuals enrolled in the P/FDS prior to the July 1, 2017 waiver renewal to ensure that participants are not subject to service loss due to changes in service rates and service definitions that became effective with the renewal. The individual cap exception allows participants to be approved at the annualized total budget projected from their approved and authorized service plan for Fiscal Year 2016-2017. These exceptions will continue for these participants through the end of Fiscal Year 2019-2020, as long as they are enrolled in the P/FDS waiver and the service plan does not exceed the approved exception level. This process will be monitored and reviewed by ODP or the AE.

• Individual cap exceptions for individuals enrolled in the P/FDS prior to July 1, 2019 to ensure that participants are not subject to service loss due to changes in Community Participation Support service rates and/or Transportation Trip zones that became effective on July 1, 2019. The individual cap exception allows participants to be approved at the annualized total budget projected from their approved and authorized service plan for Fiscal Year 2018-2019. These exceptions will continue for these participants through the end of Fiscal Year 2021-2022, as long as they are enrolled in the P/FDS waiver and the service plan does not exceed the approved exception level. This process will be monitored and reviewed by ODP or the AE.

ODP will continuously analyze and update the limit based on established rates, services authorized on service plans and utilization of those services.

ODP originally established the dollar limit as an individual cost limit. The original individual cost limit for the P/FDS Waiver was $20,000. This limit was determined through the review and analysis of statewide expenditure information and information resulting from a survey of a sample of County MH/ID Programs. The expenditure information included the costs of adult training facilities, community employment, vocational facilities, and family support services for non-waiver participants residing in non-licensed residential settings. The resulting combined average of the costs was approximately $9,000 per participant per year.

The per participant annual cost limit has been increased through waiver amendments over the past years. The average cost of services authorized on service plans for participants that were enrolled for the entire fiscal year from July 1, 2015 through June 30, 2016 was $24,800.

As per the Operating Agreement between ODP and AEs, the AE may only enroll new applicants into the P/FDS Waiver if the participant's health and welfare can be assured within the individual cost limit, or if needs not met within the cost limit will be met using non-waiver resources and/or unpaid supports. An individual needs assessment is conducted to identify services necessary to assure the person’s health and welfare. If the assessment indicates services in excess of the individual cost limit, the person may not be enrolled in the P/FDS Waiver unless their health and welfare needs will be met through non-waiver resources and/or supports. If Waiver enrollment is denied, the AE is responsible to provide the participant with their fair hearing rights, and the participant may appeal the decision. If the individual is enrolled in the P/FDS Waiver, they are informed at enrollment of the total limit.

P/FDS participants who experience a change in needs that results in service needs in excess of the individual cost limit may be transferred to the Community Living Waiver or Consolidated Waiver. The AE, with the approval of ODP, may transfer participants with current, emergency needs in excess of the P/FDS cap if the AE already has been allocated sufficient Waiver capacity and funding by ODP. If the AE does not have sufficient Waiver capacity and funding to transfer a P/FDS participant with unmet needs to the Community Living Waiver or Consolidated Waiver, the AE is to contact ODP to request additional waiver capacity and funding to transfer the participant.

P/FDS participants with needs in excess of the individual cost limit are also informed of other funding options for needed services, including state-only dollars and third party insurances. Participants are also referred to other services and supports in their communities.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
*Furnish the information specified above.*

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
*Furnish the information specified above.*

☐ **Other Type of Limit.** The state employs another type of limit.
*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, 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:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

**c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(A) The 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

Developing a participant's service plan is based on the philosophies and concepts of Positive Approaches, Everyday Lives, Person Centered-Planning, and the Community of Practice Lifecourse Framework. These philosophies and concepts capture the true meaning of working together to empower the participant and his or her family to dream, to envision a good life, and to plan and create a shared commitment for the participant's future. The purpose of Positive Approaches is to enable participants to lead their lives as they desire by providing supports for them to grow and develop, make their own decisions, achieve their personal goals, develop relationships, face challenges, and enjoy life as full participating members of their communities. The core values of Everyday Lives are choice, control, quality, community inclusion, stability, accountability, safety, individuality, relationships, freedom, and success, contributing to the community, collaboration, and mentoring. Person Centered Planning discovers and organizes information that focuses on a participant's strengths, choices, and preferences. It involves bringing together people the participant would like to have involved in the planning process, listening to the participant, describing the participant as fully as possible with a true focus on understanding who he or she is, and dreaming and imagining with the participant of possible ways things could be different, both today and tomorrow. The goal of the Community of Practice Lifecourse Framework is to support families so they can best support, nurture, and love and facilitate opportunities for the achievement of self-determination, interdependence, productivity, integration, and inclusion in all facets of community life for their family members. Integrating these values into the service plan process provides participants' and families' opportunities to incorporate their personal values, standards, and experiences in their everyday lives.

In preparation for the service plan development, the Supports Coordinator (SC) encourages meaningful participation of the participant and his/her family by informing them of the process and the concepts of Positive Approaches, Everyday Lives, Person Centered-Planning and the Community of Practice Lifecourse Framework through resource documents shared by ODP. This information and support from the service plan ensures that the participant can lead the process, if he or she chooses, to the maximum extent possible and is supported to make informed choices and decisions. The SC provides information to the participant and his or her family to understand the service plan process, who participates, options for community supports, and service delivery options.

The annotated service plan document provides a tutorial to be used during the service plan process. In addition, there are resources available through Supports Coordination Organizations (SCOs), Administrative Entities (AEs), and the Department of Human Services (DHS) website for participants and families describing the service planning and delivery process available services and providers, and rights and safeguards.

The participant and, with the participant's consent and agreement, his or her family determine who should be present and involved in the development of the service plan and determines the date, time and location of the service plan meeting. It is important to include people who know the participant best and who will offer detailed information about the participant and his or her preferences, strengths and needs. The participant and ,with the participant's consent and agreement, his or her family drive the process if they choose to do so.

The service planning process reflects cultural considerations of the participant and his or her family and is conducted by providing information in plain language and in a manner that is accessible to participant and his or her family who are limited English proficient. If the participant and his or her family use an alternate means of communication or if their primary language is not English, the information gathering and service plan development process should utilize their primary means of communication or a person who can interpret on their behalf.

In addition, the service plan must be written in plain language and in a manner that is accessible to the participant and his or her family.

(B) The Participant's Authority To Determine Who Is Included In The Process:

The participant and, with the participants consent and agreement, his or her family choose who should be present and involved in the development of the service plan with assistance from the SC if necessary. Once the service plan meeting details are confirmed, the SC develops the service plan meeting invitation and sends it to the participant, his or her family, team members and other people of the participant's choice who may contribute valuable information during the planning process.

# 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 SC develops the service plan based on information provided by the participant, his or her family and the invited team members. The team may consist of the participant, his or her family, the SC, the participant's representative which could be a common law employer or managing employer or legal guardian, providers of service, and other people who the participant chose to invite. All team members play a vital role in the development of the plan by fully participating to share knowledge, perspective and insight.

The service plan is initially developed prior to enrollment in the waiver to determine need for services and is updated annually and at any time there is a change in need or at the request of the participant.

The SC is responsible for developing the service plan by performing the following activities in accordance with specific requirements established by ODP:

• Coordination of information gathering and assessment activity, which includes the results from assessments prior to the initial and annual service plan meeting.

• Collaboration with the participant, his or her family and team members to coordinate a date, time and location for the initial and annual service plan meeting.

• Distribution of invitations to participant, his or her family and team members.

• Facilitation of the service plan meeting, or the provision of support for a participant who chooses to facilitate his or her own meeting.

• Documentation of agreement with the service plan from the participant and other team members.

• Documentation and submission of the service plan reviews and revisions to the service plan, to the AE for approval and authorization.

• Distribution of the service plan to the service plan team members who do not have access to HCSIS including service plan signature page.

• Resubmission of the service plan for approval and authorization if it was returned for revision.

Qualified providers of services are responsible for the following service plan roles and functions:

• Completion and submission of the participant's provider assessment to the SC.

• Cooperate with the team members to coordinate the date, time and location for the initial and annual service plan meeting.

• Attendance and participation in the annual service plan meeting.

• Print and review the approved and authorized service plan located in HCSIS.

• Implementation of the service plan as written.

The AE is responsible for the following service plan roles and functions:

• Review of the service plan to ensure that all assessed needs are documented and addressed through waiver or non-wavier supports.

• Approve the service plan and authorize services in accordance with the service definitions outlined in Appendix C.

• Notify the SC and providers of service once the service plan is approved and authorized.

• Approve, authorize or deny revisions to service plans.

• Approve and authorize Fiscal Year service plan prior to July 1 of each year.

(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:

ODP utilizes a multifaceted assessment process to drive the initial and ongoing service plan development. The participant's needs are identified through an assessment of functional need and are included in the service plan. In order to gain and capture person-centered information to determine the person's needs and risk factors, there is also a statewide standardized needs assessment using the Supports Intensity Scale (SIS™) and other assessment tools for population groups for whom the SIS™ is not designed and utilized. This approach provides not only for the identification of need, but the preferences and choices of the participant in the manner in which those needs should be addressed.

The SIS™ is administered by an independent contractor, and the results are available to the participant and team members in the form of the summary report. In order to receive services and to ensure that services provided can meet the needs of the participant to ensure health and welfare, all participants must have a statewide standardized needs assessment completed once every five years. If a major change in the participant's life occurs that has a lasting impact on his or her support needs, is anticipated to last more than six months, and makes his or her standardized assessment no longer current, then a new assessment should be requested. This assessment provides information essential to the service plan process as it addresses what is important both to and for the participant.

The service plan document itself identifies information about the participant; and summarizes all the assessment, outcomes and actions needed for implementation. Information gathering for the service plan should include physical development, communication abilities and needs, learning styles, strengths and functional abilities, educational background, employment, social/emotional information, medical and clinic needs (including any needs identified in a health risk screening tool when applicable), personality traits, environmental influences, community participation, interactions, preferences, outcomes, relationships that impact the participant's quality of life, and an evaluation of risk.

The service plan identifies the natural supports, medical professionals, providers of services including the frequency, duration, amount, scope, and type of services. It specifies who holds responsibility for different aspects of service plan implementation, including those related to communication, health care, risk mitigation, behavioral support, and financial support.

(C) How The Participant Is Informed Of The Services That Are Available Under The Waiver

A participant and his or her family are advised of all services available under the Waiver during the waiver enrollment process and annually or more frequently if needs change.

AEs are responsible to ensure all participants are informed of home and community-based services funded through the Waiver, including options related to participant directed services (PDS) during the waiver enrollment process.

SCs are responsible to provide information to participants and their family about services that are available under the waiver, their rights to choose willing and qualified providers to support participants' needs, and their rights to appeal at the time of the service plan meeting and at least annually thereafter. In addition, SCs are responsible for assisting participants and their family in referring and coordinating with providers that are chosen by the participants and their family and their rights to direct own services.

(D) How The Plan Development Process Ensures That The Service Plan Addresses Participant Goals, Needs(Including Health Care Needs), And Preferences

Developing a participant's service plan is based on the philosophies and concepts of Everyday Lives Values in Action, Person-Centered Planning Positive Approaches, and Community of Practice Framework. As such, the service plan addresses the full range of participant needs, identified outcomes, and preferences including but not limited to choice of residence, to seek or engage in competitive employment, community participation, control of personal resources to the same degree of access as all other persons in the community.

The SC collaborates with the participant, his or her family and the team to coordinate information gathering to include detailed information about the participant and his or her preferences, strengths, needs and experiences. The team develops outcomes that build on gathered information which reflects the individual's needs and preferences to meet those needs. Any barriers or obstacles that may affect the participant's success in achieving outcomes are discussed to ensure these obstacles do not impact the participant's health and welfare.

The service plan addresses all needs that affect the participant's health and welfare, including services that, if absent, would cause the participant to be placed in an institutional setting.

(E) How Waiver And Other Services Are Coordinated

The SC is responsible to ensure that there is coordination between services in the service plan, available MA State Plan services and other services for which the participant is eligible. The SC coordinates ODP and MA services as well as generic, unpaid, informal, natural, and specialized services and supports that are necessary to address the identified needs of the participant and to achieve the outcomes specified in the service plan. When services are being coordinated, the SC must ensure that the appropriate service is addressing the participant's needs.

(F) How The Plan Development Process Provides For The Assignment Of Responsibilities To Implement And Monitor The Plan

Once the AE approves and authorizes the participant's service plan, providers are responsible to render the needed services as written in the service plan. The SC is responsible to monitor and verify that participants receive services in the type, scope, amount, duration and frequency specified in the service plan.

To ensure that this process and related functions are performed in accordance with all applicable rules and guidelines, ODP conducts the ODP Oversight Process. This process uses a standardized monitoring tool to assess compliance across a variety of measures, including service plan development activity. Based on findings, ODP may develop a corrective action plan addressing any identified areas of concern.

(G) How And When The Plan Is Updated, Including When The Participant's Needs Change

The service plan is updated at least annually, if the participant's needs change throughout the service plan year, or at the request of the participant and his or her family. The SC will facilitate the process and coordinate needed support and services (paid, unpaid, generic and informal) in order to update the service plan as required. The AE will approve and authorize the services included in the updated service plan.

## 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 assessment process described above also identifies potential risks for the participant. Through the service plan development process, the participant, his or her family and team members develops strategies to identify, reduce and address identified risks. Each service plan contains detailed information on supports and strategies designed to mitigate risk to the participant that should align with health risk screening tools when applicable. The strategies identified to mitigate risks must reflect person-centered principles and are structured in a manner that supports participant preferences and outcomes.

A back-up plan is the strategy developed by a provider, common law employer or managing employer to ensure the services that are authorized are delivered in the amount, frequency, scope and duration as written in the participants service plan. These back-up plans are developed with the unique needs and risk factors of the participant in mind and discussed and shared with the participant, his or her family and team members. The back-up plan should address contingencies such as emergencies, including the failure of a direct support professional to appear when scheduled, or when the absence of the service presents a risk to the participant's health and welfare. In addition to the these criteria, back-up plans for remote monitoring utilized in any setting should ensure that the technology meets all applicable state and local laws, regulations and policies. These back-up plans are incorporated into the service plan by the SC to ensure that the entire team is aware of the strategies necessary to reduce and, when needed, address risks. Back-up plans are reviewed at the annual service plan meeting and revised as needed throughout the year.

Additionally, information relevant to the participant from IM4Q, ODP oversight process, Incident Management, and other feedback shall be incorporated and reviewed annually during participants' service plan meeting when that information will impact participant's health and welfare, services and supports the participant receives, or participant's ability to have an everyday life.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The SC is responsible to provide information to the participant and his or her family about willing and qualified providers of waiver services. The participant and his or her family have the authority to select the provider of their choice. The information is shared in a manner that is accessible to the participant and his or her family upon waiver enrollment, at the initial plan meeting and at least annually thereafter by sharing ODP's statewide Services and Supports Directory (SSD) and through discussions with the participant and his/her family. Information from the SSD can be reviewed through the Internet, or via hard copy.

Once a willing and qualified provider is selected, the SC will make timely referral to selected provider. A participant and his or her family may change providers at any time.

## 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 service plan meeting, the SC completes the service plan in HCSIS and it is submitted to the AE for approval and authorization in accordance with ODP policy and guidelines.

ODP reviews a proportionate representative random sample of service plans for waiver participants retrospectively as part of the annual statewide ODP Oversight Process.

The ODP Oversight Process involves the review of service plans to ensure that:

• Service plans address all participant's assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

• Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

• Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

• Participants are afforded choice between/among waiver services and providers.

• Service Plan outcomes relate to the participant's preferences and needs;

• Service plans are authorized prior to the receipt of Waiver services.

Results and findings related to the review of service plans are an important component of ODP's quality management strategy, as they relate to the assurance of meeting waiver participants' identified needs.

## 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

SCOs, AEs, and ODP are the entities responsible for monitoring the implementation of the service plan to ensure that waiver services are furnished in accordance with the service plan and consistent with safeguarding the participant's health and welfare.

(B) The Monitoring And Follow-Up Method(S) That Are Used:

SC monitoring is designed to provide support to participants and their families and allows for frequent communication to address current needs and to ensure health and safety. In addition, monitoring allows for increased support to plan for services throughout the lifespan. The monitoring maximizes support to create the quality of life envisioned by the individual, his or her family and community.

SC monitoring verifies that the individual is receiving the appropriate type, amount, scope, duration, and frequency of services to address the individual's assessed needs and desired outcome statements as documented in the approved and authorized service plan. It also ensures that the participant has access to services, has a current back-up plan and exercises free choice of providers. When changes in needs occur, the monitoring affords an opportunity for discussion and planning for increased or decreased support, as needed. Increase of monitoring frequency may be warranted based on participant's health and safety.

Information is systemically collected about the monitoring results and follow-up actions are recorded by the SC on a standardized form determined by ODP which is entered into HCSIS and/or retained in the participant's record, and is reviewed by ODP through an oversight process.

(C) The Frequency With Which Monitoring Is Performed.

For participants who receive a monthly service, the SC monitors authorized services to ensure a waiver participant's health and safety. The supports coordinator shall conduct monitoring at the following minimum frequency:

• A face-to-face monitoring once in every three (3) calendar months at a minimum.

• At least one of the face-to-face monitoring visits in every (6) six calendar months must take place in the waiver participant's home.

• One (1) visit must take place at the waiver participant's day service, including a nontraditional day program as appropriate; and

• One (1) visit may take place at:
o any location where an authorized service is rendered, as applicable in the waiver participant's plan. OR
o any location agreeable to the waiver participant.

Monitorings are not required to occur at the place of employment or educational setting but may occur with the consent of the participant and his or her employer.

For participants who receive services on a less than monthly basis, ODP requires monthly monitoring conducted by the SC with at least one face-to-face occurring every three months.

A deviation of monitoring frequency is only permitted when an individual goes on vacation or on a trip as per ODPs Waiver Travel Policy related to Service Definitions.

SCOs are responsible to monitor the quality of the SC service and implementation of the service plan.

AEs monitor implementation of the service plan on a periodic basis through the approval of service plans and authorizations of services as initially developed and as revisions are made to address changing needs of the participants.

ODP monitors through the ODP Oversight Process as well as periodic review and follow up to issues as identified through external monitoring and customer service calls.

**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:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**
**SP1 - Number and percent of participants who have all assessed needs and personal goals addressed in the service plan. Numerator = number of participants who have all assessed needs and personal goals addressed in the service plan through waiver funded services or other funding sources or natural supports. Denominator = number of participants reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Participant Record Review**

| Responsible Party for | Frequency of data | Sampling Approach |
|---|---|---|

| **data collection/generation** *(check each that applies):* | **collection/generation** *(check each that applies):* | *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 participants needs.***

**Performance Measures**

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

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

**Performance Measure:**
**SP2 - Number and percent of participants whose service plans are updated or revised at least annually. Numerator = number of participants reviewed whose service plans are updated or revised at least annually. Denominator = number of participants reviewed.**

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

If 'Other' is selected, specify:

**Participant Record Review**

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**
**SP3 - Number and percent of participants whose needs changed and whose service plans were revised accordingly. Numerator = number of participants reviewed whose needs changed and whose service plans were revised accordingly. Denominator = number of participants whose needs changed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Participant Record Review**

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

| | | |
|---|---|---|
| | | Proportionate representative random sample Confidence interval: +/-5 Confidence level: 95% |
| ☐ **Other** Specify: | ☒ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

**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:**
**SP4 - Number and percent of service plan in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the service plan. Numerator = number of service plans in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the service plan. Denominator = number of participants reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Participant Record Review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>Proportionate representative random sample Confidence interval: +/-5 Confidence level: 95% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>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:**
**SP5 - Number and percent of participants whose records document choice between and among waiver services and providers was offered to the participant/family. Numerator = number of participants whose records document choice between and among waiver services and providers was offered to the participant/family. Denominator = number of participants reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Participant Record Review**

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

**Performance Measure:**
**SP6 - Number and percent of new waiver enrollees and participants who are provided information on participant-directed services. Numerator = number of new waiver enrollees and participants who are provided information on participant-directed services. Denominator = number of new waiver enrollees and participants reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Participant Record Review**

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

| | | |
|---|---|---|
| | | Proportionate representative random sample Confidence interval: +/-5 Confidence level: 95% |
| ☐ **Other** Specify: | ☒ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:
**Participant Record Review**

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

| | | |
|---|---|---|
| | | Proportionate representative random sample Confidence interval: +/-5 Confidence level: 95% |
| ☐ **Other** Specify: | ☒ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

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

For Performance Measures SP1, SP2, SP4, SP5, and SP6, ODP staff review a proportionate, representative random sample of waiver participant records annually. For Performance Measure SP3, a subset of the proportionate, representative random sample of waiver records of participants whose needs changed is reviewed.

ODP reviews a sample of records that identify any participants for whom annual service plans are not approved within 365 days of the prior annual service plan. It is possible that an annual service plan was not completed within 365 days of the prior annual plan but was completed before the ODP review occurred (completed late). These cases are considered compliant prior to remediation.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

---

SP1. Number and percent of participants who have all assessed needs and personal goals addressed in the service plan through waiver funded services or other funding sources or natural supports. ODP reviews a sample of records to determine if participants have all assessed needs and personal goals addressed in their service plans through waiver funded services or other funding sources or natural supports. If a participant's plan does not contain evidence that all assessed needs and personal goals have been reviewed and/or addressed by the participant and his or her team, ODP will work with the SCO to ensure that the service plan is revised to support the identified assessed needs and personal goals. The SCO will provide ODP with the service plan approval date that reflects the changes made to the service plan that correct the identified noncompliance. Remediation by the SCO is expected within 30 days of notification.

SP2. Number and percent of participants whose service plans are updated or revised at least annually. If there is no evidence in the record that the service plan was completed, approved, and services authorized by the Annual Review Update Date, the AE will work with the SCO to ensure the service plan is completed within 30 days of notification.

SP3. Number and percent of participants whose needs changed and whose service plans were revised accordingly. ODP reviews a sample of records to determine if service plans were revised when a change in need was identified that required a waiver service revision. If the service plan is not revised, ODP will inform the SC that revisions to the service plan must be made. Remediation is expected to occur within 21 days of notification.

SP4. Number and percent of service plans in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the service plan. Using the sample of waiver participants, ODP reviews the individual monitoring tool completed by the SCO and claims for services delivered to ensure that services have been delivered in the type, scope, amount, duration and frequency specified in the service plan. If services were not delivered as specified in the participant's service plan, the SCO will provide documentation to ODP of the resolution. Resolution can include but is not limited to change in service provider, resumption of services at required frequency, team meetings, or changes in frequency and duration of a service. Remediation is expected to occur within 21 days of notification.

SP5. Number and percent of participants whose records document choice between and among waiver services and providers was offered to the participant/family. If there was no documentation that choice between and among services and providers was offered, ODP will direct the SC to follow-up with the participant and his or her family to provide the necessary information. The SC will use the service plan Signature Form to document that choice between and among services and service providers was offered as well as to document the date follow-up occurred. Remediation actions and submission of documentation to ODP should occur within 30 days of notification.

SP6. Number and percent of new waiver enrollees and participants who are provided information on participant-directed services. ODP will direct the SC to follow-up with the participant and his or her family to provide the necessary information. The SC will use the service plan Signature Form to document that information on participant directed services was offered as well as to document the date follow-up occurred. Documentation of remediation actions is expected to be submitted to ODP by the SCO within 30 days of notification.

**ii. Remediation Data Aggregation**

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

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix E: Participant Direction of Services

**Applicability** *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

### E-1: Overview (1 of 13)

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

ODP offers Participant Direction, also known as self-direction, in order to provide individuals and surrogates with a high level of choice and control over their services and supports. In ODP's self-direction models, the individual or surrogate directs the provision of waiver services provided by Support Service Professionals (SSPs)

Participants are able to take advantage of self-direction opportunities through the utilization of a Financial Management Service (FMS) Organization. Participants wish to self-direct services may do so though one of two FMS models: Agency with Choice (AWC) or Vendor Fiscal/Employer Agent (VF/EA).

The AWC FMS model is provided by provider agencies enrolled with ODP. Under the AWC FMS model, the AWC FMS is the "employer of record" for each SSW. In their capacity as employers of record, the AWC FMS is responsible for activities that include, but are not limited to:

• Hiring qualified SSPs referred by participants/surrogates;

• Processing employment documents;

• Verifying that qualified SSPs meet the qualification standards outlined in Appendix C-3;

• Obtaining criminal background checks and child abuse checks, if applicable, on prospective SSPs;

• Submitting claims to the Department for services authorized and rendered;

• Preparing and disbursing payroll checks;

• Providing workers compensation for SSPs;

• Providing Managing Employer skills training;

• Conducting SSP training, and

• Fulfilling any responsibilities established by ODP Bulletins

Meanwhile, the individual or surrogate serves as a Managing Employer, and enters into a joint-employment arrangement with the AWC FMS to fulfill some employment responsibilities. Managing Employers are responsible for activities that include, but are not limited to:

• Recruitment and referral of qualified SSPs to the AWC FMS for hire;

• Training SSPs to meet the participant's needs;

• Determining SSPs schedules and responsibilities, and ;

• Managing the work performed by SSPs in a supervisory capacity.

The VF/EA FMS model is provided by an entity under contract with the Department of Human Services to provide the service. In the VF/EA model, the participant or their surrogate is the Common-Law Employer of qualified SSPs. Under the VF/EA model, the FMS is responsible for functions such as but not limited to:

• Functioning as the employer agent on behalf of the participant/surrogate;

• Withholding, filing, and paying Federal employment taxes, State income taxes, and workers compensation for SSPs on behalf of the participant/surrogate;

• Paying SSPs and vendors for services rendered as per the participant's authorized service plan;

• Verifying that workers meet established qualification criteria for the service(s) they provide;

• Conducting criminal background checks and child abuse checks, if applicable, on prospective SSPs;

• Providing Common-Law Employers with informational materials relating to the VF/EA FMS model; and

• Fulfilling any responsibilities established by the Department's contract with the VF/EA FMS and ODP Bulletins

In their capacity as Common Law Employer of SSPs, the participant or their surrogate has responsibility to fulfill functions including but not limited to:

• Recruiting and hiring qualified SSPs;

• Training SSPs to meet the participant's needs;

• Determining SSPs schedules and responsibilities;

• Managing the work performed by SSPs in a supervisory capacity;

• Terminating SSP's employment when necessary; and

• Any responsibilities established by ODP Bulletins

The SCO, Supports Coordinator, AE, Provider Agencies that provide AWC FMS services, and the VF/EA FMS under contract with the Department to share the role to provide information to participants on the ODP self-directed options. The roles and responsibilities are included in the ODP policies for participant directed services. All participants must be provided information about the ODP self-directed options and the services that are identified as Participant Directed services (PDS). All participants who reside in a private home are offered the opportunity to self-direct their services.

All participants acting as the employer or managing employer are afforded the authority to designate the hourly wage paid to each qualified support service professional, in accordance with wage ranges established by ODP. All participants self-directing their services have the flexibility to manage their services and initiate shifting units and associated funds between authorized participant directed services by requesting an adjustment in their participant directed services through their supports coordinator to accommodate changes in need

All participants who self-direct their services have the right to receive those services in accordance with the guiding principles of self-determination. This means that participant-directed services must be provided in a manner that affords participants and their surrogates choice and control over the services they receive and the qualified SSPs, vendors and providers who provide them.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

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

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

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

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

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

*Specify the criteria*

Participants who live in a private home may utilize one of the identified participant directed options to manage some or all of their needed services that are available under this option. Participants who receive Residential Habilitation, Life Sharing or Supported Living services may only direct Supports Broker services through participant direction when he or she has a plan to self-direct waiver services through an AWC or VF/EA FMS in a private residence.

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

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

ODP has developed and required distribution of standard participant directed information which includes the rights and responsibilities, the benefits and any risks associated with each participant directed option. This information is included in a consumer guide to participant-direction, ODP Bulletins relating to participant direction, and ODP-approved materials provided by the VF/EA FMS or, when appropriate, an AWC FMS. Participants are provided with this information, as well as technical assistance on participant direction through the SCO, Supports Coordinator, AE and the FMS. The AE is responsible to provide waiver enrollees with information about participant direction during intake and enrollment. Supports Coordinators and SCOs are responsible to provide participants with information in advance of and during the planning process, annual service plan review, and upon request. Supports Coordinators also provide participants with support and assistance in order to make decision to exercise participant direction authority, and will refer participants to other resources (e.g. FMS, supports brokers) as necessary. Participants can also receive information and training on participant direction upon request from the SCO, AE, FMS, and ODP or its designees.

# Appendix E: Participant Direction of Services

## E-1: Overview (5 of 13)

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

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

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

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participants have the right to have a surrogate to perform the employer or managing employer responsibilities. The FMS is responsible to ensure that the selected surrogate agrees to fulfill the responsibilities of the employer or managing employer by ensuring the completion of the applicable ODP standard agreement form. If a surrogate is desired by the participant, the surrogate must:

• Effectuate the decision the participant would make for himself/herself;

• Accommodate the participant, to the extent necessary that they can participate as fully as possible in all decisions that affect them;

• Give due consideration to all information including the recommendations of other interested and involved parties; and

• Embody the guiding principles of self-determination.

A participant may designate any person 18 years of age or older as a surrogate unless a surrogate has been designated by a court or is otherwise limited by existing or pending legal action prohibiting someone from serving as a surrogate.

A surrogate may not receive payment for functioning as a surrogate, nor may they receive payment for any waiver service provided by the surrogate with the exception of Transportation mileage reimbursement as defined in Appendix C1/C3.

The FMS must recognize the participant's surrogate as a decision-maker, and provide the surrogate with all of the information, training, and support it would typically provide to a participant who is self-directing. The FMS must fully inform the surrogate of the rights and responsibilities of a surrogate in accordance with established procedures. FMS must have the surrogate review and sign an ODP standard agreement form, which must be given to the surrogate and maintained by the FMS. The agreement lists the roles and responsibilities of the surrogate; asserts that the surrogate accepts the roles and responsibilities of this function; and asserts that the surrogate will abide by ODP policies and procedures. ODP maintains the discretion to determine whether the Managing or Common-Law Employer is in compliance with the agreement and may require termination of the agreement with or without cause.

Service plan monitoring takes place with each participant at the minimum frequency outlined in D-2-a. Several questions on the standard service plan monitoring tool can prompt the identification of any issues with the surrogate not acting in the best interest of the participant. Issues noted on the monitoring tool are addressed by Supports Coordinators, the SCO provider, FMS, the AE and/or ODP.

The AWC FMS is required to address and report any issues identified with the surrogate's performance including but not limited to compliance to the ODP policy on incident reporting and report any incident of suspected fraud or abuse.

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

| Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| **Participant-Directed Goods and Services** | ☒ | ☒ |
| **Specialized Supplies** | ☒ | ☒ |
| **Companion** | ☒ | ☒ |
| **Respite** | ☒ | ☒ |

| Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| **Supported Employment** | ☒ | ☒ |
| **Supports Broker Services** | ☒ | ☒ |
| **Assistive Technology** | ☒ | ☒ |
| **Family/Caregiver Training and Support** | ☒ | ☒ |
| **Transportation** | ☒ | ☒ |
| **In-Home and Community Support** | ☒ | ☒ |
| **Vehicle Accessibility Adaptations** | ☒ | ☒ |
| **Home Accessibility Adaptations** | ☒ | ☒ |
| **Homemaker/Chore** | ☒ | ☒ |
| **Education Support Services** | ☒ | ☒ |

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**

☒ **Private entities**

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

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

◉ **FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

The AWC FMS model is provided by provider agencies qualified and enrolled by ODP. The VF/EA FMS model is provided by an entity under contract with the Department to provide the service. The entity is procured through the Commonwealth of Pennsylvania’s competitive bidding process.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

ODP has developed a standard methodology for reimbursing FMS administrative activities and the administrative payments to the VF/EA FMS and AWC FMS are entirely separate from the funds dedicated to the participant's budget for services.

AWC FMS providers receive a monthly per-participant administrative fee for the FMS administrative service provided by the AWC FMS. The monthly administrative fee is established by ODP through the fee schedule rate development process and must be applied consistently with each participant within the AWC FMS provider. Administrative claims are submitted by the AWC FMS to PROMISe and payments are made directly to the AWC FMS from the Pennsylvania Treasury.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☒ **Other**

*Specify:*

Criminal background check
Qualifications check

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

*Specify:*

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☒ **Other**

*Specify:*

The FMS receives and disburses funds for the payment of vendor services. The statewide VF/EA FMS and AWC FMS providers may subcontract for goods needed for a participant that have been designated as PDS vendor services. In these situations, the VF/EA and AWC FMS is responsible to ensure that subcontracted entities meet all applicable provider qualification standards for the service. In addition, the VF/EA and AWC FMS must complete the following activities for the service offered/rendered:

• Enroll in PROMISe as the provider;

• Ensure the requirements of Appendix C, including provider qualification standards, are met;

• Cooperate with provider monitoring conducted by ODP or one of its designees;

• For AWC FMS providers, cooperate with other monitoring activities, such as Supports Coordination monitoring, and ensure the vendor cooperates with such monitoring when necessary. For VF/EA providers, cooperate with monitoring activities as specified in the VF/EA's contract with the Department; and

• Maintain documentation on service delivery in accordance with state and federal requirements.

The cost of the good or vendor service must be the same as charged to the general (or self-paying) public. Any administrative charge is included in VF/EA and AWC FMS monthly per participant fee.

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

VF/EA FMS provides specific employer agent functions that support the participant with the employer-related functions. The Department monitors the VF/EA FMS to ensure that the contract deliverables are met and participants are in receipt of VF/EA FMS services in accordance with their service plan. The statewide VF/EA FMS is monitored by agents of the Department every two years. A sample of participants' records are reviewed for compliance onsite at the vendor's service location. If noncompliance is identified, the provider is issued a Corrective Action Plan with which it must comply. Additionally, ODP monitors the VF/EA FMS on an ad hoc basis when concerns arise about contract deliverables. AEs are also required to report any issues with the statewide FMS organization's performance to ODP, pursuant to the AE Operating Agreement.

AWC FMS providers are monitored by AEs once during each three year provider monitoring cycle as described in Appendix A-6. AWC FMS providers are subject to provider monitoring activities conducted using standard tools and data collection documents specific to AWC FMS providers to verify that providers are qualified and services are provided in compliance with the Waiver and federal and state requirements.

SCOs monitor participant service delivery at a frequency identified in Appendix D-2-a which includes the delivery of the administrative services provided by the AWC and VF/EA FMS. ODP through its ODP Oversight Process verifies that SCOs are performing the necessary functions relating to AWC and VF/EA requirements.

ODP monitors claims submitted by the AWC FMS and VF/EA FMS. Through the ODP established claims oversight methods, which include AWC FMS-specific provider monitoring and monitoring the VF/EA FMS contract requirements, ODP has safeguards to ensure the payments to the FMS providers for both administrative fees and services are in accordance with all applicable regulations and requirements and maintain a consistent ratio of services to the FMS administrative costs for the participants.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their

services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

Supports Coordination is a service furnished under the Waiver. In accordance with the Supports Coordinator core functions to locate, coordinate and monitor services the Supports Coordinators must provide participants with the ODP developed or approved information such as consumer guides to self-direction, ODP policy bulletins on participant direction, the ODP established wage ranges and the ODP approved statewide Vendor Fiscal/Employer Agent (VF/EA) start up packet. The Supports Coordinator and SCO provide the participant with a basic overview of the participant directed options, the differences and responsibilities associated with each option. The Supports Coordinator and SCO provide contact information for the statewide VF/EA on contract with ODP as well as the ODP designated Agency with Choice (AWC) in their Administrative Entity. The Supports Coordinator or SCO is required to share the above information during the planning process, annual service plan review meetings, and upon request. Supports Coordinators also provide participants with support and assistance to make the decision to exercise participant direction authority (ies), and refer participants to other resources (i.e. FMS, supports brokers) as necessary. If a decision is made to self-direct some or all the needed services, the participant and his or her team will then select either the AWC or VF/EA FMS option. Documentation of the choice is documented by the Supports Coordinator on the service plan Signature Page. In addition to providing information and assistance to support a participant with decisions on the option to self direct, the Supports Coordinator also supports the participant with designating a surrogate and transition activities when needed.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| **Participant-Directed Goods and Services** | ☐ |
| **Behavioral Support** | ☐ |
| **Therapy Services** | ☐ |
| **Music Therapy, Art Therapy and Equine Assisted Therapy** | ☐ |
| **Specialized Supplies** | ☐ |
| **Advanced Supported Employment** | ☐ |
| **Community Participation Support** | ☐ |
| **Companion** | ☐ |
| **Benefits Counseling** | ☐ |
| **Respite** | ☐ |
| **Small Group Employment** | ☐ |
| **Supported Employment** | ☐ |
| **Supports Broker** | ☒ |

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| **Services** | |
| **Assistive Technology** | ☐ |
| **Family/Caregiver Training and Support** | ☐ |
| **Transportation** | ☐ |
| **Consultative Nutritional Services** | ☐ |
| **In-Home and Community Support** | ☐ |
| **Family Medical Support Assistance** | ☐ |
| **Family Medical Support Assistance** | ☐ |
| **Shift Nursing** | ☐ |
| **Communication Specialist Services** | ☐ |
| **Supports Coordination** | ☒ |
| **Vehicle Accessibility Adaptations** | ☐ |
| **Home Accessibility Adaptations** | ☐ |
| **Homemaker/Chore** | ☐ |
| **Housing Transition and Tenancy Sustaining Service** | ☐ |
| **Education Support Services** | ☐ |

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

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

Participants in the VF/EA FMS model or their surrogates who function as the “Employer” may access orientation and functional training or may obtain enrollment and informational materials from the statewide VF/EA FMS organization on contract with ODP.

Participants in the AWC FMS model or their surrogates who function as the “Managing Employer” may access orientation, functional and ongoing training or may obtain enrollment and informational materials from the AWC FMS provider.

The scope of information and assistance supports include the provision of PDS participants with ODP developed or approved information such as consumer guides to self-direction, ODP policy bulletins on participant direction, the ODP established wage ranges, and, for VF/EA participants, the comprehensive Enrollment Packet referred to as the “startup packet”. AEs, SCOs, ODP, the VF/EA FMS and the AWC FMS share the responsibility of sharing this information.

PDS participants are provided a basic overview of the participant directed options and the differences and responsibilities associated with each option as well as contact information for the statewide VF/EA on contract with ODP as well as the ODP designated Agency with Choice (AWC) in their Administrative Entity.

Participants are provided with support and assistance to make the decision to exercise participant direction authority and are referred to other resources (i.e. Supports Brokers) as necessary, as well as a basic overview of the participant directed options and the differences and responsibilities associated with each option.

Participants are provided with contact information for the statewide VF/EA FMS as well as the ODP designated AWC FMS in their Administrative Entity.

Participants are also assisted with designating a surrogate and transition activities when needed.

Participants in the VF/EA FMS model or their surrogates who function as the “Employer” may access orientation and functional training or may obtain enrollment and informational materials from the statewide VF/EA FMS organization on contract with ODP.

Participants in the AWC FMS model or their surrogates who function as the “Managing Employer” may access orientation, functional and ongoing training or may obtain enrollment and informational materials from the AWC FMS provider

SCOs monitor participant service delivery at a frequency identified in Appendix D-2-a of this waiver which includes the delivery of the administrative services provided by the AWC and VF/EA FMS. ODP through its ODP Oversight Process verifies that SCOs are performing the necessary functions relating to AWC and VF/EA requirements.

As noted in E-1-I-iv, ODP monitors the VF/EA FMS to ensure that the contract deliverables are met and participants are in receipt of VF/EA FMS services in accordance with their service plan. Both AEs and ODP are responsible for assessing AWC FMS performance.

SCOs monitor participant service delivery at a frequency identified in Appendix D-2-a of this waiver which includes the delivery of the administrative services provided by the AWC and VF/EA FMS. As specified in Appendix D-2-a of the waiver, ODP oversees the ODP Oversight Process, which would include assessing SCO and AE performance regarding monitoring administrative services provided by the AWC and VF/EA FMS.

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** *(select one).*

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

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

If a participant or surrogate functioning as the “Employer” voluntarily terminates themselves from the VF/EA FMS participant directed model, the Supports Coordinator will provide the participant with options to choose the AWC FMS model or agency-based service options to meet their needs. The Supports Coordinator is responsible to work with the participant, surrogate, and service plan team to ensure an effective transition between participant directed and traditional services so that there are no gaps in service. The Supports Coordinator is responsible to work with the participant, surrogate and service plan team to monitor and coordinate an effective transition between service management options so the participant’s health and welfare is maintained and services are provided in accordance with the authorized service plan.

If a participant or surrogate functioning as the “Managing Employer” voluntarily terminates themselves from the AWC FMS participant directed model, the Supports Coordinator will provide the participant with the option to choose another AWC FMS provider to the extent that one is available, the VF/EA FMS model or agency-based service options to meet their needs. The Supports Coordinator is responsible to work with the participant, surrogate, and service plan team to ensure an effective transition between participant directed and traditional services so that there are no gaps in service. The SC is responsible to work with the participant, surrogate and service plan team to monitor and coordinate an effective transition between service management options so the participant’s health and welfare is maintained and services are provided in accordance with the authorized service plan.

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination will occur if the participant is suspected or convicted of Medicaid fraud or if there is sufficient evidence that the participant's assessed needs are not being met through the self-direction of services as determined by ODP.

If a participant involuntarily terminated from the VF/EA FMS participant directed model, the supports coordinator will provide the participant with options to meet their needs though the Agency with Choice FMS model, an agency-based service option, or a combination thereof.

If a participant is involuntarily terminated from the AWC FMS participant directed model, the Supports Coordinator will provide the participant with options to choose an agency-based service options to meet their needs.

ODP may at its discretion remove a surrogate functioning as an employer in either the VF/EA or AWC FMS model if the surrogate is suspected or convicted of Medicaid fraud or fails to meet the condition of their signed agreement. Surrogates shall not have the right to appeal such removals.

ODP may at its discretion may require the termination of a worker in either the VF/EA or AWC FMS model if the worker is suspected or convicted of Medicaid fraud or demonstrates an inability to meet the participant's assessed needs as determined by ODP.

The Supports Coordinator is responsible to work with the participant, surrogate and service plan team to maintain health and welfare, monitor and coordinate an effective transition between participant directed and traditional services and monitor that services are provided in accordance with the authorized service plan.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

**n. Goals for Participant Direction.** In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

**Table E-1-n**

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|---|---|---|
| **Waiver Year** | **Number of Participants** | **Number of Participants** |
| **Year 1** | | 2500 |
| **Year 2** | | 2500 |
| **Year 3** | | 2500 |
| **Year 4** | | 2500 |
| **Year 5** | | 2500 |

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

**a. Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The participant or the participant's representative (surrogate) functions as the managing employer of their workers who provide the authorized services. The Agency With Choice (AWC) is the employer of record of the staff. The AWC performs the employer of record functions, payroll and human resources functions. When needed and when authorized a Supports broker also may assist the managing employer with their employer-related functions.

Provider agencies function as AWC FMS providers. Under the AWC FMS model, the AWC FMS and the participant/surrogate must collaborate to offer a high level of choice and control to participants/surrogates, but the AWC FMS is ultimately responsible for ensuring that this occurs. The focus of the AWC FMS is to afford participants/surrogates with the ability to be effective managing employers and to support them in recruiting and referring workers to the AWC FMS for hire, managing worker day-to-day responsibilities and schedules, and discharging workers from the home when necessary. The AWC FMS must fully embrace and apply the philosophies of self- determination and self-directed support services by providing participants/surrogates with a high level of choice and control over the how services identified by the service plan process are provided and the workers who provide them. AWC FMS providers are responsible to develop and maintain a system and written policies and procedures that reflect ODP policy and afford participants/surrogates with the ability to recruit, interview, and select qualified support service workers for hire by the FMS; as well as the ability to be managing employers.

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Background check requirements in the participant directed services models are the same as outlined in appendix C-2-a and are conducted by the AWC or VF/EA FMS organization.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

- ☒ **Orient and instruct staff in duties**
- ☒ **Supervise staff**
- ☒ **Evaluate staff performance**
- ☒ **Verify time worked by staff and approve time sheets**
- ☒ **Discharge staff (common law employer)**
- ☐ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

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

Specify:

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

Information about these method(s) must be made publicly available.

Participants' needs, preferences, and goals are identified through a multifaceted assessment process that captures person-centered information. Assessment results are used to develop the participants' service plans, which determine the medical, social, habilitation, education, or other services necessary to achieve their desired outcomes. The participant's budget is determined by the total units and total costs for the waiver services authorized in the service plan.

ODP has established wage ranges for Support Service Professionals for services that can be participant-directed. Participants or their surrogates and Support Service Professionals negotiate wages within the established wage ranges and in accordance with Labor and Industry standards. The negotiated wages for all services must be within the service-plan established budget.

The above processes are consistently applied to each participant.

Bulletins, information packets, wage ranges/rates, and other information are participant-directed services is published on the Department's website at www.MyODP.org. This information is accessible by participants, stakeholders, and the general public.

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

The participant or his or her surrogate is part of the service plan team. The service plan team develops the service plan, including the authorized budget. The Administrative Entity with which the participant is registered must review and authorize the service. The participant's Supports Coordinator notifies the participant when the plan, including the authorized budget, is approved.

Participants may request an adjustment to the budget amount through their Supports Coordinator, who will modify the service plan to reflect an increase or decrease in services and a corresponding change in budget. The adjusted service plan is reviewed and approved by the Administrative Entity. If a service plan adjustment is denied or the participant's services are reduced, the Administrative Entity is responsible to provide written notice and appeal rights to the participant. The participant may choose exercise his or her right to appeal.

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

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

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

# Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

The participant or his/her surrogate is responsible for effective management of the participant's budget in their capacity as common-law or managing employer. The common-law and managing employer agreements specify that budget management is an employer responsibility.

The timely prevention of the premature depletion of the participant-directed budget is safeguarded by monitoring and interventions conducted by the FMS Agent, the Administrative Entity, and the participant's Supports Coordinator. AWC FMS providers invoice for services provided, process and disburse payroll checks, and are responsible to do so in accordance with the participant's authorized service plan. The AWC FMS provides monthly statements to the managing employers so they can appropriately track utilization of services and the corresponding funds. The VF/EA FMS organization on contract with the State is responsible for invoicing services provided, and processing and disbursing payroll checks, and is responsible to do so in accordance with the participant's authorized service plan. The VF/EA FMS organization records funds received and disbursed, as well as remaining balances for each participant. All of these actions serve as a means of tracking available funds to prevent budgetary depletion. Administrative Entities monitor participants' budgets through a review of paid claims. Supports Coordinators may become aware of potential budgetary depletions through the monitoring or service plan processes.

If potential premature depletion of the participant-directed budget is identified, the supports coordinator and/or the FMS are responsible to notify the participant or their surrogate of the potential depletion, and to provide assistance in adjusting the participants' use of services or negotiated Support Service Professional wages to avoid budgetary depletion. This may include revising the participants' service plan as described in E-2-b-iii. Supports broker services may also be recommended to ensure participants' effective management of services and corresponding budget.

# Appendix F: Participant Rights

## Appendix F-1: Opportunity to Request a Fair Hearing

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

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

An individual/participant is advised routinely of his or her due process and appeal rights in accordance with ODP policies. The SC is responsible for notifying participants of the opportunity to request a fair hearing at his or her initial service plan meeting and at least annually during the service plan annual review meeting and any time the participant requests to change services or add new services. The discussion will be documented on the service plan and through a service note in Home and Community Services Information System (HCSIS).

The AE or ODP (for services that require prior authorization) is required to issue due process and appeal rights to the individual/participant utilizing standard forms any time the following circumstances occur:
• The individual, who is determined likely to meet an ICF/ID or ICF/ORC level of care and is enrolled in Medical Assistance, is not given the opportunity to express a service delivery preference for either Waiver-funded or ICF/ID or ICF/ORC services.

• The individual is denied his or her preference of Waiver-funded or ICF/ID or ICF/ORC services.

• Based on a referral from the AE or County Program, a Qualified Developmental Disability Professional (QDDP) determines that the individual/participant does not require an ICF/ID of ICF/ORC level of care as a result of the level of care determination or redetermination process and eligibility for services is denied or terminated.

• The individual/participant is denied his or her request for a new Waiver-funded service(s), including the amount, duration, and scope of service(s).

• The individual/participant is denied the choice of willing and qualified Waiver provider(s).

• A decision or an action is taken to deny, suspend, reduce, or terminate a Waiver-funded service authorized on the participant's service plan.

The Department's fair hearing and appeals process does not apply to the following actions:

• Changes caused solely by Federal or State law or regulations requiring an automatic change adversely affecting some or all recipients (42 CFR 431.220 [relating to Hearings]).

• Changes solely established by a Waiver amendment approved by the Centers for Medicare and Medicaid Services.

• A non–Medicaid service funded outside of the Waiver.

• A service provided during a period in which the individual is ineligible for Waiver funding.

The AE or ODP is required to make all such notices in writing. Should the individual/participant choose to file an appeal, they must do so with the agency that made the determination being questioned. Title 55 Pa. Code §275.4(a)(2) states that individuals must file an appeal with the agency that made the determination being questioned, and §275.1(a)(3) specifically includes social service agencies: "the term Department includes, in addition to County Assistance Offices, agencies which administer or provide social services under contractual agreement with the Department."

It is the responsibility of the Supports Coordinator to provide any assistance the individual or participant needs to request a hearing. This may include the following:

• Clearly explaining the basis for questioned decisions or actions.

• Explaining the rights and fair hearing proceedings of the individual or participant.

• Providing the necessary forms and explaining to the individual or participant how to file his or her appeal and, if necessary, how to fill out the forms.

• Advising the individual or participant that he or she may be represented by an attorney, relative, friend or other spokesman and explaining that he may contact his local bar association to locate the legal services available in the county.

Certain Waiver actions related to level of care and Medicaid ineligibility are also subject to fair hearing and appeal procedures established through the local County Assistance Office (CAO). AE participation is expected in preparation for the hearing and at the hearing whenever the CAO sends a notice confirming the level of care determination and the individual or surrogate appeals that notice through the CAO. The AE will receive notice of the hearing from the Department.

In situations where services are denied without first being authorized in the service plan or for actions taken regarding waiver service delivery preference, the individual or participant is provided 30 days from the written notice mailing date to appeal the decision. The AE or ODP is required to provide an advance written notice of at least 10 calendar days to the participant anytime the AE initiates action to reduce, suspend, change, or terminate a Waiver service. The advance notice, which is sent by the AE or ODP, shall contain a date that the appeal must be received by the AE or ODP to have the services that are already being provided at the time of the appeal continue during the appeal process.

If the participant files an appeal (written or oral) within 10 calendar days of the mailing date of the written notification from the AE, the appealed Waiver service(s) are required to continue until a decision is rendered after the appeal hearing (55 Pa. Code § 275.4(a)(3)(v)(C)(I)). As noted above, the continuation language is included in the written notice that is sent to the participant by the AE or ODP. The postmark of a mailed appeal will be used to determine if the 10 day requirement was met by the participant or surrogate.

If the AE initiates an action on Waiver services and does not provide the written notice as required, the participant will have 6 calendar months from the effective date of the action to file an appeal. When this appeal is filed, services will be reinstated retroactively to the date of discontinuance and will continue until an adverse decision is rendered after the appeal hearing.

Per the AE Operating Agreement, each AE is required to keep notices of adverse actions and the opportunity to request a Fair Hearing in accordance with the timeframes enumerated in the agreement.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The participant has the right to request an optional pre-hearing conference with the AE or ODP, as applicable (55 Pa. Code § 275.4(a)(3)(ii) [relating to Procedures]). The pre-hearing conference gives both parties the opportunity to discuss and attempt to resolve the matter prior to the hearing. Neither party is required to change its position. The prehearing conference does not replace or delay the fair hearing process.

In addition to pre-hearing conferences, service reviews are conducted by ODP for fair hearing requests for participants that relate to the denial, reduction, suspension, or termination of waiver services by the AE and do not require prior authorization. Service Reviews are used to ensure AE compliance with regulations, approved Waivers, the State Medicaid Plan and applicable Bulletins.

The AE must track decisions and timely implementation of the service review or Bureau of Hearings and Appeals decision ODP has established a database to track appeals submitted and the outcome.

Final orders issued by the Department’s Bureau of Hearings and Appeals must be implemented within 30 calendar days of the final order if ruled in favor of the appellant. If there is continued failure to implement the service, the ODP regional office will notify the County Commissioners/AE Governing Board of the program’s failure to provide waiver services in accordance with their Operating Agreement and require an immediate plan from the Commissioners/AE Governing Board to comply. Any further failure to implement the service will result in sanctions being imposed in accordance with the AE Operating Agreement.

## 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:

ODP is responsible for the operation of a grievance/complaint system.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ODP's grievance/complaint system is comprised of two main components. The first is a Customer Service Line; the second is via email. Participants, family members and representatives, AEs, providers, advocates, and other interested parties may use these two components to ask questions, request information, or report any type of issue or complaint, including issues/complaints regarding AE performance.

The Customer Service Line (1-888-565-9435) is a general information line operated by ODP. The phone is located at ODP Headquarters and staffed by ODP personnel during normal business hours. Contacts can also be received via email at RA-odpcontactdpw@pa.gov. The DHS website also offers a “feedback” page for users who wish to comment on intellectual disability and autism services. Feedback, when received, is automatically forwarded to ODP.

When a complaint/grievance is received through the Customer Service Line or by email, information relating to the complaint/grievance is obtained and entered into a database. Information collected includes, but it not limited to the complainant’s contact information and the nature of the complaint. The information is then referred to headquarters staff or the appropriate ODP regional office for follow-up. The complainant is contacted within 24 hours and corrective action is planned in conjunction with the AE or provider, if warranted.

Corrective action must occur or be planned within 21 business days, unless there is an imminent health and safety risk, in which case corrective action is taken immediately. If corrective action is not carried out by the AE or provider as planned, then ODP staff will contact the appropriate entity to ensure that corrective action is undertaken or planned within 72 hours.

In addition all ODP regional offices utilize a “duty officer” system whereby assigned staff are responsible for any complaints/grievances received directly at the regional office. Phone calls and letters are also received directly at ODP and responded to accordingly.

Providers are required to develop procedures to receive, document and manage grievances. The provider is responsible for informing the participant, and persons designated by the participant, upon initial entry into the provider’s program and annually thereafter, of the right to file a grievance and the procedure for filing a grievance. The grievance shall be resolved within 21 days from the date the grievance was received. The initiator of the grievance shall be provided a written notice of the resolution or findings within 30 days from the date the grievance was received.

The AE, ODP or the provider is responsible for informing individuals that any of the grievance/complaint systems described above is neither a pre-requisite, nor a substitute for a fair hearing.

## Appendix G: Participant Safeguards

# Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ODP uses an electronic, web-based reporting solution for incident reporting and management known as the Enterprise Incident Management (EIM) system. All provider entities and supports coordination organizations are considered reporting entities and use EIM to report incidents to ODP and the AEs. The ODP incident lifecycle contains an initial notification process (known as the first section submission), a formalized investigation if warranted, a final notification process (known as the final section submission), and an approval process (known as the closure of the incident).

When an event occurs, or is alleged to have occurred, that is considered an incident per policy, the initial notification is made by the reporting entity (provider or supports coordination organization) by submitting the first section of the incident report to ODP and the AE within 24 hours of discovery or recognition. This first section of the incident report includes a description of the event, incident categorization, as well as the action taken to ensure the health and safety of the individual. Once the initial notification is submitted, the AE will review the incident first section to ensure that prompt action was taken to protect the participant's health, safety, and rights. If the actions taken are insufficient, the AE will contact the reporting provider and direct additional actions.

All incidents are investigated to rule out or identify instances of abuse, neglect, or exploitation. In addition, certain categories of incidents require the investigation to be completed by an ODP certified investigator. These include incidents of abuse, neglect, misuse of funds, death and rights violations. Misuse of funds and rights violations are considered exploitation.

Abuse is defined as an allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Abuse is reported on from the victim's perspective, not on the person committing the abuse.

-Physical abuse. An intentional physical act by staff or other person which causes or may cause physical injury to an individual, such as striking or kicking, applying noxious or potentially harmful substances or conditions to an individual.

-Psychological abuse. An act, other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

-Sexual abuse. An act or attempted acts such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Any sexual contact between a staff person and an individual is abuse.

-Verbal abuse. A verbalization that inflicts or may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

-Improper or unauthorized use of restraint. A restraint not approved in the individual support plan or one that is not a part of an agency's emergency restraint procedure is considered unauthorized. A restraint that is intentionally applied incorrectly is considered an improper use of restraint.

Neglect is defined as the failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law or regulation. This includes the failure to provide needed care such as shelter, food, clothing, personal hygiene, medical care, protection from health and safety hazards, attention and supervision, including leaving individuals unattended and other basic treatment and necessities needed for development of physical, intellectual and emotional capacity and well-being. This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm.

Exploitation is defined as Misuse of funds and Rights violation.

-Misuse of funds. An intentional act or course of conduct, which results in the loss or misuse of an individual's money or personal property. Requiring an individual to pay for an item or service that is normally provided as part of the individual support plan is considered financial exploitation and is reportable as a misuse of funds. Requiring an individual to pay for items that are intended for use by several individuals is also considered financial exploitation. Individuals may voluntarily make joint purchases with other individuals of items that benefit the household.

-Rights violation. An act which is intended to improperly restrict or deny the human or civil rights of an individual including those rights which are specifically mandated under applicable regulations. Examples include the unauthorized removal of personal property, refusal of access to the telephone, privacy violations and breach of confidentiality. This

does not include restrictions that are imposed by court order or consistent with a waiver of licensing regulations.

As part of the investigation, an investigator must take their first witness statement within 24 hours of being assigned an investigation. The investigator must also complete all witness interviews within 10 days of being assigned the investigation. The investigation and a final investigation determination (either confirmed or not confirmed) must be completed within 30-days.

An incident report is considered finalized when the reporting entity submits the Final Section of the incident report to ODP and the AE. Where appropriate, the final section of the incident will include the investigation determination as well as the corrective actions that were carried out or planned in order to mitigate and prevent the reoccurrence of the incident. All incident reports must be finalized within 30-days from the date of discovery or recognition or the incident report is not considered timely. If the reporting entity is unable to finalize the incident report within 30 days due to circumstances beyond its control, the provider entity shall notify ODP that an extension is necessary and provide the reason for the extension. When the need for an extension is submitted, the reporting entity is obligated to adhere to the extension deadline otherwise the finalization of the incident report is not considered timely.

When the reporting entity finalizes an incident report, the AE performs a review of the incident report within 30-days from the date of finalization. This review ensures that the incident was managed effectively and according to policy and that the investigation determination is supported by evidence, corrective actions are appropriate, planned, and prevents reoccurrence, and other pertinent information is included as necessary. Once the AE concludes their review of the incident report, ODP performs a second level review.

In addition to reporting incidents to ODP and the AE, Pennsylvania also has protective service laws in place for children (ages 0-17), adults with disabilities (ages 18-59), and older adults (ages 60 an over). All provider entities are mandated by law to report incidents of abuse, neglect, exploitation, and suspicious death to the protective services agencies defined in regulation.

Below is a listing of the types of incidents that require reporting within 24 hours of occurrence or discovery.
(1) Death.

(2) A physical act by an individual to commit suicide.

(3) Inpatient admission to a hospital.

(4) Abuse.

(5) Neglect.

(6) Exploitation.

(7) An individual who is missing for more than 24 hours or who could be in jeopardy if missing at all.

(8) Law enforcement activity that occurred during the provision of an HCBS or for which an individual is the subject of a law enforcement investigation that may lead to criminal charges against the individual.

(9) Injury requiring treatment beyond first aid.

(10) Fire requiring the services of the fire department not including responses to false alarms.

(11) Emergency closure.

(12) A violation of individual rights.

(13) Theft or misuse of individual funds.

The following the types of incidents that require reporting within 72 hours of occurrence or discovery.

(1) Use of a planned, emergency restraint.

(2) A prescription medication administration error.

The following types of incidents require a formalized investigations to be completed by a Department-certified incident investigator:

(1) Death.

(2) Inpatient admission to a hospital as a result of an accidental or unexplained injury or an injury caused by a staff person, another individual or during the use of a restraint.

(3) Abuse.

(4) Neglect.

(5) Exploitation.

(6) An injury requiring treatment beyond first aid as a result of an accidental or unexplained injury or an injury caused by a staff person, another individual or during the use of a restraint.

(7) Theft or misuse of individual funds.

(8) A violation of individual rights.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Supports Coordinators deliver and discuss information concerning protections from abuse, neglect, and exploitation, including how to notify appropriate authorities. Each waiver participant receives a document that includes contact information for Supports Coordinators, local authorities, family members, and advocacy organizations. Waiver participants, families, and/or legal representatives can use this information as needed to report concerns regarding abuse, neglect, and exploitation. The document also includes ODP’s toll-free Customer Service Line number. This information is discussed at least annually or more frequently as determined necessary by the Supports Coordinator and at the request of a participant or caregiver.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

ODP and AEs both receive initial notification within the EIM system, when the first section of the incident report is submitted by a provider or SCO. Also, ODP and AEs both receive notification when the final section of the incident report is submitted by a provider or SCO. In addition, if the provider operates a licensed setting, the state licensing authority also receives notifications.

In accordance with the ODP policy on Incident Management, within 24 hours of the initial notification, the AE evaluates the report to ensure that:

• The provider took prompt action to protect the participant's health, safety and rights. This may include, but is not limited to contacting emergency services such as 911, arranging medical care, separating the perpetrator and victim, arranging counseling or referring to a victim assistance program.

• When applicable, the provider met the mandatory reporting requirements by contacting the appropriate protective services agency for children, adults with a disability, or older adults.

• The provider notified the family or guardian of the incident within 24 hours (unless otherwise indicated in the individual support plan).

• When applicable, the provider initiated an investigation by assigning the case to an ODP Certified Investigator (CI).

ODP requires separation of the victim from the alleged perpetrator (also known as the "target" of the investigation) when an allegation of abuse, neglect, or exploitation is made, and the individual's health and safety are jeopardized. Targets may not have contact with any participants registered to receive services until the investigation is concluded. This separation may include suspending or terminating the alleged target. ODP also complies with Pennsylvania's ACT 28/26, which requires reporting the abuse or neglect of care-dependent persons to the State Attorney General's office and/or the local District Attorney's offices.

When a participant who is residing with his or her family experiences an incident that jeopardizes the victim's health and safety, the provider, AE or ODP will seek the assistance of law enforcement or Protective Service Agencies, who have the authority to remove the alleged perpetrator or the victim from the home or environment to ensure safety.

Incidents of abuse, neglect, misuse of funds, rights violation and death are investigated by persons that have completed the Department's approved certification course. Certified Investigators (CI) follow protocols established by the ODP as part of the investigatory process. Investigators accommodate the witness's communication needs as appropriate and conduct interviews individually, and in a private place, if possible. If the witness requires the presence of a third party, the CI must arrange for third party representation (i.e. a staff person or family member).

The provider then completes and finalizes the report, including the investigation summary, within 30 days of the incident. The AE and ODP evaluate all finalized reports within 30 days of their notification and approve the report if:

• The appropriate action to protect the participant's health, safety and rights occurred;

• The incident was correctly categorized;

• Timely completion of the certified investigation occurred;

• The investigation summary supports the conclusion;

• Safeguards to prevent reoccurrence are in place;;

• Corrective actions have occurred, or are planned to occur, in response to the incident to prevent reoccurrence. When corrective actions are planned the anticipated date of completion must be indicated;

• Changes were made in the participant's plan of support necessitated by or in response to the incident;

• The participant or participant's family received notification of the findings by the reporting entity prior to the finalization of the incident report, unless otherwise indicated in the individual plan; and

• Incidents of abuse, neglect and exploitation were reported to the appropriate authority as required by Pennsylvania Law.

The AE and ODP disapprove reports that fail evaluation. Disapproved reports revert to the provider, who corrects any deficiencies and resubmits the report for re-evaluation. The AE will continue to work with and monitor the provider to ensure appropriate adherence to the established policies. ODP staff evaluates approved reports within 30 days and, if satisfactory, closes the incident report.

If additional time is needed to finalize the report the provider can have the timeframe deadlines extended. Situations that may warrant an extension of time may include but are not limited to: discharge from hospital has not occurred, investigation is not complete due to law enforcement involvement or criminal justice activities, or witnesses are not able to be interviewed timely due to extenuating circumstances.

Supports Coordinators identify unreported incidents as they conduct monitoring of services and supports including documentation reviews. AEs identify unreported incidents as they conduct provider monitoring oversight activities. ODP identifies unreported incidents as part of the waiver participant record review sample. When an unreported incident is identified, the reviewer communicates this finding immediately to the AE and/or the provider who is required to ensure that an incident report is filed and appropriate action is taken to mitigate the incident and ensure action is taken to prevent reoccurrence

**e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

ODP is responsible for the oversight of and response to incidents. ODP evaluates all finalized reports, and completes a management review within 30 days after the AE approves the incident report. This oversight occurs on an ongoing basis. In addition, ODP reviews significant events monthly and provides technical assistance when a need is identified.

The EIM system supports incident management for ODP by allowing for the documentation and analysis of incident data. Data from EIM is used to support implementing quality improvement, risk management and incident management processes for all levels of the support and service system. Through a review of the data ODP identifies factors that put participants at risk and facilitates the development of interventions and improvement activities to mitigate future risk or reoccurrence. Key data elements of the incident management system include:
• Evidence of prompt and appropriate action in response to incidents.

• Timely reporting of incidents.

• Investigation of incidents.

• Corrective action in response to incidents.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

**a. Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

**i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ODP only permits physical restraints, defined as a manual method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely. Physical restraints may only be used in the case of an emergency to prevent an individual from immediate physical harm to himself or others. A physical restraint may not be used for more than 30 cumulative minutes within a 2-hour period.

Physical restraints must be used only as a last resort safety measure when the participant is in immediate danger of harming oneself and/or others and other risk mitigation strategies are ineffective. A physical restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for individual support.

The following restraints are prohibited:

• Prone position physical restraints and any physical restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints or allows for a free fall to the floor is prohibited.

• Aversive conditioning, defined as the application of startling, painful or noxious stimuli.

• Pressure point techniques, defined as the application of pain for the purpose of achieving compliance. A clinically-accepted bite release technique that is applied only as long as necessary to release the bite is not considered a pressure point technique.

• A chemical restraint, defined as a drug used for the specific and exclusive purpose of controlling acute, episodic behavior. A Pro Re Nata (PRN) order for controlling acute, episodic behavior is a chemical restraint.

• A mechanical restraint, defined as a device used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body including a geriatric chair, bedrail that restricts the movement or function of the individual, helmet with fasteners, waist strap, head strap, restraint vest, camisole, restraint sheet, restraint board, handcuffs, anklets, wristlets, muffs and mitts with fasteners and similar devices. A mechanical restraint does not include the use of a seat belt during movement or transportation.

Physical restraints must be included in the service plan and must be approved by a human rights team prior to implementation. The service plan must be reviewed and revisions must be made to the service plan when necessary, according to the time frame established by the human rights team, not to exceed 6 months.

The service plan with restrictive interventions, plan including physical restraints, must include:
(1) The specific behavior to be addressed.
(2) An assessment of the behavior including the suspected reason for the behavior.
(3) The outcome desired.
(4) Methods for facilitating positive behaviors such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, recognizing and treating physical and behavior health conditions, voluntary physical exercise, redirection, praise, modeling, conflict resolution, de-escalation and teaching skills.
(5) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.
(6) A target date to achieve the outcome.
(7) The amount of time the restrictive procedure may be applied.
(8) The name of the staff person responsible for monitoring and documenting progress with the individual plan.

Through review of the incident report and individual support plans, ODP monitors the use of approved physical restraints and the procedures used. This process is also used to ensure that no providers have utilized the prohibited practices of seclusion or prone position manual restraint.

The use of a physical restraint is always a last resort emergency response to protect the participant's safety. Consequently, it is never used as a punishment, therapeutic technique or for staff convenience. The

participant is immediately to be released from the physical restraint as soon as it is determined that the participant is no longer a risk to himself/herself or others. Additionally, regulations specifically state "Every attempt shall be made to anticipate and de-escalate the behavior using techniques less intrusive than a restrictive procedure." Service plans identify strategies to avoid the need for restraints. These plans identify the antecedents, thereby enhancing opportunity to intercede before the use of restraint is needed.

A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.

ODP detects unauthorized or misapplied physical restraints through the various oversight and monitoring processes. Physical restraints that do not follow ODP standards are reported as abuse.

Regulations require provider staff that administers physical restraints to have specific training regarding the appropriate use and safe implementation, as well as de-escalation techniques/alternatives. This training must be completed within the past 12 months and focus on the proper procedures and specific techniques to follow, ethics of using physical restraints and alternative positive approaches.

ODP utilizes a person-centered planning model for all activities associated with provider training for authorized physical restraints. Training and education for administering a physical restraint is based on the unique needs of the individual as outlined in the service plan. ODP requires that staff associated with waiver services that may need to employ a physical restraint be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs (these education and training requirements are outlined in Appendix C: Participant Services C-1/C-3: Service Specification).

Training curricula and frequency is directly related to the person centered plan that includes the use of a physical restraint. According to regulation, frequency of staff training must occur prior to rendering services to a participant.

Examples of the types of education and trainings include multiple nationally recognized intervention programs that focus on the use of least restrictive interventions such as Safe Crisis Management Certification Training Program and Crisis Prevention Institute's techniques of Nonviolent Crisis Management.

According to ODP policy, a participant's physical condition must be evaluated throughout the physical restraint in order to minimize the potential of individual harm or injury. A participant is immediately released from a physical restraint when they no longer present a danger to self or others. Support staff monitors the participant for signs of distress throughout the restraint process and for a period of time (up to two hours) following the application of a physical restraint.

All anticipated physical restraint usage must be reviewed prior to usage with the individual's Primary Care Physician (PCP) to ensure that there are no potential negative health and safety impacts. For example a PCP may not agree to allow a physical restraint to be used for an individual with osteoporosis due to the risk of a broken bone.

**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:

During licensing surveys and oversight monitoring activities, the Department and ODP validates that restraints, if administered, were applied in accordance with requirements. The AE or Department has the authority to review and require revisions or the removal of any restrictive intervention from a service plan. When restraints are used, they are reported as incidents in the EIM system by the entity that employed the restraint. These entities must conduct a monthly analysis of restraint usage to identify trends and patterns and to support strategies to reduce restraint usage at the organization. ODP verifies during oversight monitoring that these activities are being conducted. Physical restraints that are employed and do not follow ODP guidelines are reported as an incident of abuse and investigated. As a result of the investigation and the incident management process, strategies are developed to prevent reoccurrence. In addition, through the person-centered planning process, teams regularly meet to review and discuss progress, lack of progress, and any overuse or misuse of restraints.

As part of the Department's annual licensing inspection process for licensed settings, licensing staff reviews incidents to identify participants who have been restrained and to verify regulations have been met. Providers that frequently use restraints are provided technical assistance, training and other resources needed to decrease the use of restraints.

ODP completes an analysis to identify trends and patterns on a quarterly basis. Improvement strategies are developed based on the outcome of restraint data analyses.

## 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.

Behavior support plans with restrictive procedures must be developed and approved by a human rights team prior to implementation. The behavior support plan with restrictive procedures must be reviewed, and revised, if necessary, according to the time frame established by the human rights team, not to exceed 6 months.

The service plan with restrictive interventions including physical restraints must include:
(1) The specific behavior to be addressed.
(2) An assessment of the behavior including the suspected reason for the behavior.
(3) The outcome desired.
(4) Methods for facilitating positive behaviors such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, recognizing and treating physical and behavior health conditions, voluntary physical exercise, redirection, praise, modeling, conflict resolution, de-escalation and teaching skills.
(5) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.
(6) A target date to achieve the outcome.
(7) The amount of time the restrictive procedure may be applied.
(8) The name of the staff person responsible for monitoring and documenting progress with the individual plan.

Permitted Restrictive Interventions include:

• Token economies or other reward and/or level systems as part of programming.

• Environmental restrictions

• Limiting access to objects or items, such as limiting access to food for participants diagnosed with Prader Willi.

• Intensive supervision such as 1:1 or 2:1 staffing levels or higher, for purposes of behavior monitoring/intervention/redirection.

• Anything that a person is legally mandated to follow as part of probation or a court restriction that is superseded by regulation or other ODP policy.

Prohibited restrictive interventions include:

• The use of aversive conditioning; defined as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful or noxious stimuli, is prohibited.

• A participant's personal funds or property may not be used as reward or punishment. A participant's personal funds or property may not be used as payment for damages unless the participant consents to make restitution for the damages.

A restrictive procedure may not be used as retribution, for the convenience of 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 procedures every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures. A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.

ODP requires documentation of restrictive intervention usage as part of the progress notes completed by provider staff. ODP utilizes a person-centered planning model for all activities associated with provider training for authorized restrictive interventions. Training and education surrounding restrictive interventions are based on the unique needs of the individual as outlined in the behavior support plans with restrictive procedures. The curriculum is based on the specific techniques outlined in the behavior support plans with restrictive procedures. ODP requires that staff associated with waiver services that may need to employ a restrictive intervention be trained to meet the unique needs of the participant which includes but is not

limited to communication, mobility and behavioral needs (these education and training requirements are outlined in Appendix C: Participant Services C-1/C-3: Service Specification).

Training curricula and frequency is directly related to the person centered plan that includes the use of restrictive interventions. According to regulation, frequency of staff training must occur prior to rendering services to a participant.

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

ODP oversees the use of restrictive interventions through oversight monitoring activities. Behavior support plans with restrictive procedures are approved by a human rights team prior to the use of any restrictive intervention. The only exception to using a restrictive intervention without an approved plan is when the intervention is used for the first time during an emergency situation in order to protect the health and safety of a participant. Restrictive interventions that do not follow ODP guidelines are reported as an incident of a rights violation and investigated. As a result of the investigation and incident management process strategies are developed to prevent reoccurrence. In addition, through the person-centered planning process, the team regularly meets to review and discuss progress, lack of progress, and any overuse of restrictive interventions.

As part of the Department's annual licensing inspection process for licensed settings, licensing staff reviews service plans to identify participants who have restrictive interventions in place and to verify that regulations regarding behavior support plans with restrictive procedures have been met. Providers that frequently use restrictive interventions are provided technical assistance, training and other resources needed to decrease the use of restrictive intervention usage.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

ODP prohibits seclusion as a type of restrictive intervention. ODP is the state agency responsible for monitoring and overseeing the use of restrictive interventions to ensure that seclusion is not a method being used. When alleged seclusion has been identified, the usage is reported as an incident of a rights violation and investigated. As a result of the investigation and incident management process, strategies are developed to prevent reoccurrence.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

**i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

First-line responsibility for monitoring participant medication regimens resides with the medical professionals who prescribe and the pharmacists who dispense medications.

The second line medication monitoring occurs through Supports Coordinator (SC) review of the participant's services to ensure that all programs are administering medications appropriately. For participants taking any type of medication, the SCs review the medication regimen during each face-to-face monitoring visit using the service plan monitoring tool which lists: the medication that the participant takes; the reason for the medication; the total daily dose; whether or not blood levels are necessary; and what the medication is supposed to do. Monitoring to detect potentially harmful practices related to medication occurs for all waiver participants that take medication. The elements of the tool designed to do this include: looking at the completeness and correctness of medication administration documentation; efficacy of medication; knowledge of side effects and strategy to report; changes in medications or presence of side effects; changes in health that might be related to medication; and appropriate and timely communication about health issues between medical practitioners and the participant's team. Supports Coordinators also document allergies. The service plan monitoring tool is used to monitor medication given at home, including a licensed residential setting, and at a day program. Monitoring of medication occurs three times a quarter in different locations. Participants that are prescribed behavior modifying medications are required to have their medication reviewed by the prescribing psychiatrist at least every 3 months. Supports Coordinators ensure these reviews are occurring during each face-to-face monitoring visit.

Monitoring is designed to detect potentially harmful practices and ensure follow up to address such practices. If concerns or issues related to medication administration are discovered at a face-to-face monitoring visit, the Supports Coordinator communicates this information directly with the individual's team. The SC can also seek assistance from the Health Care Quality Units (HCQUs) or ODP regional nurses and medical director to perform a medication review so that strategies can be developed to address the concerns or issues. The regional nurses and the HCQUs are available for targeted training and technical assistance with regard to questions about medications and their administration. All HCQUs provide training and outreach to SCOs and AEs on a regular basis.

Department licensing also monitors medication and medication administration. Providers with licensed sites are monitored using a sampling strategy. Licensing personnel review medication administrator certification as well as medication regimens on Medication Administration Records as compared to the physician documentation to assure consistency between the two. As well they compare allergies and unusual reactions to medication to the medication list to detect any use of contraindicated medications. ODP nurses may be involved when medication regimens are complex or licensing personnel have questions about the implementation of the medication course to provide clinical input. Regional nurses meet regularly with the ODP Medical Director and are able to review medication related concerns.

Reviews of medications for participants, particularly those with complex medication regimens or behavior modifying medications as part of their treatment program, can occur through a number of methods, including discussions with ISP team members; training sessions with the HCQUs related to how to look at medications related to medical and behavioral conditions; and based on issues and concerns noted during monitoring.

ODP uses the DHS Medication Administration Program (MAP) to teach unlicensed staff to give medication to participants using a standard curriculum. The MAP course requires periodic reviews of staff performance to maintain certification. Record of completion of these reviews is maintained at the provider level and must be available for licensing review. The MAP course teaches staff to review medication when it is received from the pharmacy and compare it to the Medication Administration Records, thus providing a regular review of medications by provider staff. Part of the documentation and safety measures include looking at medication allergies for the possibility of a contraindicated drug.

**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.

ODP oversees the Medication Administration Program, which is designed to teach proper medication administration to unlicensed staff. Lessons covered in the Program are intended to increase safety, minimize potentially harmful practices and include: Observations, Reporting Changes, Communication and Healthcare Practitioner Visit, Recording and Storage of Medication, Handwashing and Gloving, Administration, Documentation, Medication Errors, and Self-administration of Medication.

ODP regional risk managers provide ongoing monitoring of reported medications errors. ODP regional risk managers collaborate with ODP regional nurses, the medical director, and HCQU staff to assure reporting occurs while working to prevent known causes of medication errors. ODP regional nurses may also monitor the provider activities around medication administration, usually in response to either a problem related to licensing surveys or a request from the provider because of issues at the agency. The nurses also may provide technical assistance with respect to medication errors and the implementation of the medication program. They then follow-up on these recommendations and any plans of correction required by licensing related to medication administration to assure that the potentially harmful practices are remedied. In addition the HCQUs have developed guidance for providers regarding medication administration policies and procedures to supplement what is in the MAP course. HCQUs also provide technical assistance regarding medication administration and implementing changes to prevent errors.

Despite ODP's extensive medication administration course, medication errors sometimes occur. ODP requires providers to report medication errors via Enterprise Incident Management (EIM) within 72 hours of occurrence or discovery. The EIM medication error report utilizes a root cause analysis approach, requiring the reporter to answer a series of questions aimed at identifying what happened as well as the contributing factors that can then be addressed and minimized. The questions include: "Why did the error occur?", "What was the response to the error?" "What was or will be the agency system response to prevent this type of error from occurring in the future?" This approach also informs the curriculum offered in the medication management course and allows for process improvement.

If a medication error is the result of a critical incident, such as neglect or results in a critical incident, such as death, then it is not reported as a medication error but rather as the higher level critical incident. The incident is then subject to investigation and AE and regional review.

Medication error reporting data, including remediation data, is aggregated, analyzed and discussed at ODP's Community Services Quality Oversight Group for opportunities to design and implement system improvements regarding medication errors.

## 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 are specified for waiver providers regarding: medication administration, storage and disposal of medication, labeling of medication, prescription medications, medication record, medication errors and adverse reactions. State regulations allow for the administration of medication by unlicensed staff when trained using a standard Medication Administration course. Licensed nurses are not required to take the administration course as this is part of their clinical scope of practice under the State Nursing Board. State regulation specifies waiver provider responsibilities when participants self-administer. 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:

The Department of Human Services, Office of Developmental Programs via an electronic database, EIM which is accessible by the state, AEs, Supports Coordinators and providers.

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

There are no types of medication errors that providers are required to record, but not report.

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

Providers report medication errors as specified in Enterprise Incident Management (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.

○ **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.

ODP monitors performance of providers in the administration of medication to waiver participants both directly and indirectly. As described in section G-3bi, direct monitoring occurs through annual Department licensing reviews. In addition, the ODP Oversight Process indirectly evaluates individual waiver participant's medication information. Each AE is monitored by reviewing a sample of waiver participants' records. Direct monitoring occurs when the AEs and Supports Coordinators monitor medications for participants. Supports Coordinators monitor medication administration and practices in the manner described in G-3bii. AEs monitor the performance of Supports Coordinators and review medication errors through their risk management processes including evaluating the information about how the errors occurred in order to intervene with a provider that shows poor medication administration practices. Health Care Quality Units (HCQUs) also provide indirect monitoring of medication administration through their individual case and provider reviews. When HCQUs, Supports Coordinators, and AEs review medications, the results are communicated to ODP in a number of ways. Provider issues related to implementation of the Medication Administration Program course are referred to the nurses or the Medical Director to be addressed either at the level of the provider or the level of the course. Licensing documents findings in their licensing reports, and communicates any issues around the implementation of the course to the regional nurses and the ODP Medical Director by phone, email or in person.

The reporting strategy for medication errors facilitates a root cause analysis on the part of the provider related to each specific medication error. Problems with specific providers regarding medication administration practices are remediated in a number of ways. The nurses from ODP provide technical assistance to the providers around their medication practices especially those that are identified as being unsafe or problematic. The medication administration course itself includes a set of standard remediation strategies for medication administrators that have made errors in order to assure that they know how to properly administer and document related to that particular situation. The HCQUs provide training and technical assistance to providers on an ongoing basis to promote the use of best practices around medication administration.

The required medication administration course teaches problem solving and has been modified to address problems identified through data captured in EIM. The HCQUs, AEs, and regional risk management committees review medication errors on a regular basis. ODP reviews reports submitted by the AE. The AE reviews reports submitted by providers. Any medication error resulting in a critical incident requires investigation. ODP reviews lead to changes in the medication administration instrument and additional training. Health Alerts are issued and distributed widely on specific drug issues.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

**a. Methods for Discovery: Health and Welfare**

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the*

*method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**HW1 Number & percent of confirmed incidents of abuse, neglect, exploitation, unexplained death for which corrective actions executed or planned by appropriate entity in required time frame. Numerator = # of confirmed incidents of abuse, neglect, etc. which corrective actions executed or planned by appropriate entity in required time. Denominator = # of confirmed incidents of abuse, neglect, etc.**

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

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**
**HW2 - Number and percent of participants who received information about how to identify and report abuse, neglect, and exploitation. Numerator = number of participants who received information about reporting abuse, neglect, and exploitation. Denominator = number of participants in the sample.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Participant Record Review**

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

| | | |
|---|---|---|
| | | Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95% |
| ☐ **Other** Specify: | ☒ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

**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:**
**HW3 - Number and percent of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame. Numerator = number of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame. Denominator = all critical incidents, by type of incident.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☒ **Other**<br>Specify:<br>Semi-annually |

**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:**
**HW4 - Number and percent of participants with restrictive interventions where proper procedures were followed. Numerator = number of participants with restrictive interventions where proper procedures were followed. Denominator =**

**number of participants with a restrictive intervention plan reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

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

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

**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:**
**HW5 - Number and percent of participants whose identified health care needs are being addressed. Numerator = number of participants whose identified health care needs are being addressed. Denominator = number of participants reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Participant Record Review**

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

| | | |
|---|---|---|
| | | **Sample**<br>Confidence Interval =<br>Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

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

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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HW1. Number and percent of confirmed incidents of abuse, neglect, exploitation and unexplained death for which corrective actions were executed or planned by the appropriate entity within the required time frame. The AE and ODP sequentially review confirmed critical incidents to ensure that corrective actions resulting from certified investigation are carried out or planned by the appropriate entity within the required time frame. If corrective actions are not carried out or planned by the appropriate entity within the required time frame, the AE or ODP will follow up with the provider to ensure the corrective actions are carried out or planned within 10 days. All remediation steps are entered into the incident report and are subject to final approval by ODP. Supports Coordinators monitor for completion of planned corrective actions through the individual monitoring process.

HW2. Number and percent of participants who received information about reporting abuse, neglect, and exploitation. ODP reviews a sample of participant records to determine if participants/families have been provided information about reporting abuse, neglect and exploitation. If there was no documentation that the information was provided, ODP will direct the SC to follow-up with the individual and his or her family to provide the necessary information. The SC will use the service plan Signature Form to document that information about reporting abuse, neglect, and exploitation was offered as well as to document the date follow-up occurred. Documentation of remediation actions is expected to be submitted to ODP by the SCO within 30 days of notification.

HW3. Number and percent of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame. ODP staff monitors a monthly report of critical incidents that are not finalized, including strategies to mitigate/prevent future incidents, within 30 days and have no extension filed. This information is provided to AEs who contact providers to determine why incidents have not been finalized and why extensions have not been filed. If a provider does not finalize a critical incident within the required time frame, including strategies to mitigate/prevent future incidents, the provider must finalize the incident within 5 days or file an extension request.

HW4. Number and percent of participants with restrictive interventions where proper procedures were followed. ODP staff monitors a monthly report of all incidents where proper procedures were not followed related to the use of a restraint or restrictive intervention. When proper procedures have not been followed, staff responsible for employing the restraint or restrictive intervention will be retrained on the individual's restrictive intervention plan, retrained on applicable policies and procedures that address the prohibition of unallowable restraints or restrictive invention techniques, or terminated by the agency.

HW5. Number and percent of participants whose identified health care needs are being addressed. Using the sample of waiver participants, ODP reviews monitoring conducted by the participant's Supports Coordinator. The ODP standardized individual monitoring tool includes questions evaluating whether identified health care needs are addressed as specified in the service plan. In any instance where the Supports Coordinator identifies a concern regarding addressing identified health care needs, and the issue remains unresolved, ODP will work with the SCO to resolve the situation. Resolution can include but is not limited to resumption of services at the required frequency, additional assessment by the current service provider, pursuit of a second opinion/consultation from an alternate provider, changes in service provider, team meetings, or changes in service schedule. The SCO will provide documentation of the resolution to ODP. Remediation is expected to occur within 30 days of notification.

**ii. Remediation Data Aggregation**

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

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |
| | ☐ **Continuously and Ongoing** |
| | ☒ **Other**<br>Specify:<br>Semi-annually |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

**Quality Improvement Strategy: Minimum Components**

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

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

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and

- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

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

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

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

## Appendix H: Quality Improvement Strategy (2 of 3)

### H-1: Systems Improvement

**a. System Improvements**

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

ODP has developed Quality Oversight Groups in each of its four Regional Offices to review region-specific aggregate discovery and remediation data in each of the six waiver assurance areas and a Community Services Quality Oversight Group to review statewide aggregate performance data in each of the six waiver assurance areas. ODP Regional Office Staff are assigned to participate in the compilation and analyses of aggregate data pertaining to their region, then join with ODP Central Office staff to compile and analyze data statewide. Regional analysis, conclusions, and recommendations are considered when statewide analysis is performed; conclusions and recommendations proposing system-wide improvements are made by the Community Services Quality Oversight Group.

ODP selects for review a proportionate, representative, random sample of waiver participants, with a confidence level of 95%, margin of error 5%, from the combined population of waiver participants in Pennsylvania's Consolidated Waiver Control #0147, P/FDS Waiver Control #0354 and Community Living Waiver Control #1486. The results obtained reflect the performance of the combined system, ensuring that the system for the waivers is responsive to the needs of all individuals served. ODP trends, prioritizes and implements system improvements (i.e., design changes) prompted as a result of an analysis of the discovery and remediation information obtained. ODP chooses this holistic approach because the following five conditions are met:

1. The design of Pennsylvania's Consolidated, P/FDS and Community Living Waivers is the same;
2. This sameness is determined by comparing waivers on the approved waiver application appendices:
   a. Participant Services,
   b. Participant Safeguards, and
   c. Quality Management;
3. The quality management approach is the same across waivers, including:
   a. Methodology for discovering information (e.g., data systems, sample selection),
   b. Manner in which individual issues are remedied,
   c. Process for identifying and analyzing patterns/trends, and
   d. All performance indicators are the same;
4. The provider network is the same; and
5. Provider oversight is the same.

Because Pennsylvania's Consolidated, P/FDS and Community Living Waivers are approved for the same five-year time frame, ODP will submit a consolidated evidence report reflecting the first three state fiscal years' performance on the combined system on the schedule CMS requires.

Improvement activities selected by the Community Services Quality Oversight Group are also identified and evaluated in consideration of ODP's overarching mission, vision and values. ODP's mission, vision and values are developed in partnership with stakeholders and communicated statewide. Health and safety of individuals and the achievement of individual outcomes through person-centered planning are given highest priority.

ODP assigns staff to implement quality improvements based on the scope of the design change and the expertise required. ODP involves additional stakeholders including Administrative Entities, providers, supports coordination entities, individuals served and their families, and other State agencies in consideration of the design change involved and specific input needed.

Information used for trending and prioritizing opportunities for system improvements is also obtained through Independent Monitoring for Quality (IM4Q), a statewide method the State has adopted to independently review quality of life issues for people who receive services from ODP that includes a sample of waiver participants. IM4Q monitors satisfaction and outcomes of participants receiving services through indicators organized into areas of satisfaction, dignity and respect, choice and control, inclusion, and physical setting. IM4Q also monitors satisfaction with supports coordination services. Pennsylvania also collects and submits data to National Core Indicators through the IM4Q process and compares its performance to the aggregate performance of all States participating in National Core Indicators when identifying strengths and opportunities for systemic improvement.

Aggregate IM4Q data is used for continuous quality improvement purposes by ODP, AE and provider quality groups. Recommendations for action are also identified by the IM4Q Steering Committee and submitted for consideration to ODP's Information Sharing and Advisory Committee (ISAC). The ISAC serves as ODP's stakeholder quality council. ODP prioritizes opportunities for system improvements in conjunction with the

ISAC, then disseminates these priorities to the field. Stakeholders representing their constituencies on the ISAC are expected to collaborate with ODP in the implementation, monitoring and evaluation of changes designed to achieve system improvements using a data-based approach.

**ii. System Improvement Activities**

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Quality Improvement Committee** | ☒ **Annually** |
| ☐ **Other**<br>Specify: | ☐ **Other**<br>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.

ODP uses a Plan-Do-Check-Act (PDCA) Model of continuous quality improvement. The steps in this model involve planning and implementing system design changes followed by monitoring of data results to check the effectiveness of the selected strategies. Using the analysis of performance data collected to identify next steps, the cycle is repeated. Depending on the area of focus, specific units within ODP are assigned responsibility for designing, initiating, monitoring and analyzing the effectiveness of system design changes and providing periodic, routine reports on progress to the Community Services Quality Oversight Group. Stakeholders are engaged in this process where appropriate. In addition, ODP's ISAC completes the PDCA Cycle through review of IM4Q and NCI data, assessing the effectiveness of strategies implemented and identifying next steps.

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

On an annual basis, considering input from Quality Oversight Groups and the ISAC, ODP's Executive Staff assesses program and operational performance as well as ODP's Quality Management Strategy. Results of this review may demonstrate a need to revise ODP's QMS, including changing priorities, using different approaches to ensure progress, modifying roles and responsibilities of key entities, and modifying data sources in order to retrieve the information needed for measurement.

## Appendix H: Quality Improvement Strategy (3 of 3)

### H-2: Use of a Patient Experience of Care/Quality of Life Survey

**a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):***

○ **No**

◉ **Yes** *(Complete item H.2b)*

**b. Specify the type of survey tool the state uses:**

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

## *Appendix I: Financial Accountability*

### *I-1: Financial Integrity and Accountability*

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

*The method employed to assure the integrity of payments made for waiver services is to conduct an annual audit of state government, Administrative Entities (AEs), and for profit and nonprofit organizations in accordance with the requirements of 2 CFR Part 200, Subpart F as well as Title 45, CFR 75.501(i). As outlined in the waiver cost report instructions, all sub-recipients expending less than $750,000 of federal funding and $750,000 or more in combined state/federal Funding (for profit and non-profit) need to have an annual audit conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS). If the sub-recipient is a nonprofit entity that expended $750,000 or more in federal funding, an audit in accordance with 2 CFR Part 200, Subpart F is required. 2 CFR Part 200, Subpart F requires a single audit or if the auditee expends federal awards under only one program, a program-specific audit conducted in accordance with GAGAS. If the sub-recipient is a for-profit entity expending $750,000 or more in federal funding, the entity has the option to either have an annual audit in accordance with 2 CFR Part 200, Subpart F or a program specific audit conducted in accordance with GAGAS.*

*The Department of the Auditor General, an independent office, jointly conducts the annual Commonwealth of Pennsylvania Single Audit with an independent CPA firm. 2 CFR Part 200, Subpart F sets forth standards for obtaining consistency and uniformity for the audit of States, local governments, and non-profit organizations expending federal awards. Providers are audited exclusively by contracting with CPA firms. Providers may also be selected for a GAGAS performance audit by the Department's Bureau of Financial Operations.*

*Beginning on July 1, 2017, both traditional providers (which includes SCOs) and AWC FMS providers are reviewed by the Department (ODP or AEs) through the Quality Assessment and Improvement (QA&I) process on a 3-year cycle. During ODP's QA&I process, ODP performs a desk review of a representative, random sample of claims annually to determine if they are supported by adequate provider documentation to substantiate that services were delivered. This includes providers that fall below the $750,000 threshold. The population of claims used for fiscal monitoring will coincide with the providers and SCOs being monitored in a given year. Providers will submit documentation as described in the ODP Bulletin #00-17-02 or its successor to substantiate claims. This will be done via email to a dedicated mailbox at ODP. If ODP finds inadequate provider documentation to support a claim, depending on the nature of the issue, additional records will be selected for review by ODP and the Department may initiate an expanded review or audit.*

*The Department monitors the VF/EA FMS to ensure that the contract deliverables are met and participants are in receipt of VF/EA FMS services in accordance with their service plan. The statewide VF/EA FMS is monitored by agents of the Department. The contract includes a set of minimum standards which the VF/EA must meet or exceed in order to ensure that claims are processed corrected. Additionally, the financial integrity and accountability of the Common-Law Employer is monitored through submission of overtime and utilization reports. The overtime report is used to ensure that Support Service Professional overtime is scheduled in accordance with ODP's policies. The utilization report is used to ensure that the participant is not over-utilizing the service. Overutilization usually includes services rendered above the authorized amount in the service plan, but unusually high utilizations may also be investigated. This also includes participants with service authorizations in their service plans that fall below the $750,000 threshold.*

*through the desk review, the Department ensures waiver services billed were actually rendered by pulling a random, representative sample of claims using a 95% confidence level and 5% margin of error and reviews claims for accuracy and to assure that documentation adequately supports the claim. Results of post-payment reviews will be communicated with the provider's QA&I results.*

*Fraudulent and/or inaccurate billings discovered during the QA&I process will trigger an expanded review by ODP or referral to the Bureau of Financial Operations or the Bureau of Program Integrity depending on the nature and extent of the finding. Inappropriate billings are required to be refunded by the provider and further remediation up to termination may occur.*

## *Appendix I: Financial Accountability*

### *Quality Improvement: Financial Accountability*

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

***a. Methods for Discovery: Financial Accountability Assurance:***

***The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.*** *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology*

*specified in the approved waiver.")*

***i. Sub-Assurances:***

***a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.***
*(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

***Performance Measures***

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

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

***Performance Measure:***
***FA1 - Number and percent of claims that are supported by documentation that services were delivered. Numerator = number of claims reviewed that are supported by documentation that services were delivered. Denominator = number of claims reviewed.***

***Data Source*** *(Select one):*
***Other***
*If 'Other' is selected, specify:*
***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***<br>*Confidence Interval =*<br>*Representative random sample Confidence interval: +/-5 Confidence level: 95%* |
| ☐ ***Other***<br>*Specify:* | ☒ ***Annually*** | ☐ ***Stratified***<br>*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:***
***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:*
***PROMISe***

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

| *(check each that applies):* | *(check each that applies):* | |
|---|---|---|
| ☒ ***State Medicaid Agency*** | ☐ ***Weekly*** | ☒ ***100% Review*** |
| ☐ ***Operating Agency*** | ☐ ***Monthly*** | ☐ ***Less than 100% Review*** |
| ☐ ***Sub-State Entity*** | ☐ ***Quarterly*** | ☐ ***Representative Sample***<br>*Confidence Interval =* |
| ☐ ***Other***<br>*Specify:* | ☐ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☒ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |

| ***Responsible Party for data aggregation and analysis*** *(check each that applies):* | ***Frequency of data aggregation and analysis****(check each that applies):* |
|---|---|
| | ☐ ***Other***<br>*Specify:* |

***Performance Measure:***
***FA3 - - Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Numerator = number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Denominator = number of claims paid.***

***Data Source*** *(Select one):*
***Other***
*If 'Other' is selected, specify:*
***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***<br>*Confidence Interval =* |
| ☐ ***Other***<br>*Specify:* | ☐ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☒ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

***Performance Measure:***
***FA3 - Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Numerator = number of claims coded and paid in accordance with the reimbursement methodology specified in the approved waiver. Denominator = number of claims paid.***

***Data Source*** *(Select one):*
***Other***
*If 'Other' is selected, specify:*
***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***<br>*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 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:***
***FA4 - Percent of waiver claims paid using rates that follow the rate methodology in the approved waiver application. Numerator = percentage of claims paid using rates that follow the rate methodology in the approved waiver application. Denominator = all waiver claims paid.***

***Data Source*** *(Select one):*
***Other***
*If 'Other' is selected, specify:*
***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***<br>*Confidence Interval =* |
| ☐ ***Other***<br>*Specify:* | ☐ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☒ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

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

*FA1 - ODP reviews a representative, random sample of claims annually to determine if they are supported by adequate provider documentation to substantiate that services were delivered.*

*FA2 - The reimbursement logic built into Pennsylvania's Medicaid Management Information System (MMIS) ensures that waiver participants were eligible for services on the date the service was provided, and that services paid are authorized in the participant's approved service plan. A problem may be identified by a provider or providers, contractors, Administrative Entities (AEs), ODP staff, or the Office of Medical Assistance Programs (OMAP). The ODP Claims Resolution Section monitors claims activity on a monthly basis to identify potential issues with the eligibility information, or services paid inconsistent with the services authorized in the service plan.*

*FA3 - The reimbursement logic built into Pennsylvania's Medicaid Management Information System (MMIS) ensures that providers are not paid more than the rate that is stored in the system. A problem may be identified by a provider or providers, contractors, AE, ODP staff, or OMAP. The ODP Claims Resolution Section monitors claims activity on a monthly basis to identify potential issues with the reimbursement rate.*

*FA4 - The reimbursement logic built into Pennsylvania's Medicaid Management Information System (MMIS) ensures that providers are not paid more than the rate that is stored in the system. A problem may be identified by a provider or providers, contractors, AE, ODP staff, or OMAP. The ODP Claims Resolution Section monitors claims activity on a monthly basis to identify potential issues with the reimbursement rate.*

***b. Methods for Remediation/Fixing Individual Problems***

***i.*** *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

*FA1 - Number and percent of claims that are supported by documentation that services were delivered. If ODP finds inadequate provider documentation to support a claim, depending on the nature of the issue, additional records will be selected for review by ODP and the Department may initiate an expanded review or audit. If indicated, ODP will work with the AE to conduct further claims review and remediation activities as appropriate. The provider will be requested by the AE to submit a corrective action plan that will specify the remediation action taken. Remediation is expected to occur within 30 days. Remediation may include locating documentation to support that services rendered are consistent with claim submission, training, voiding (and/or recovering) payments, and the initiation of provider sanctions, if the situation warrants. Department sanctions may range from restricting the provider from serving additional participants to the termination of the agency's waiver program participation. Department staff will ensure that payments are adjusted where necessary and determine if the extent of the problem warrants further action.*

*FA2 -Number and percent of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans. If a problem is identified, outreach is conducted with the provider and appropriate corrective action is conducted in a timely manner. Providers are expected to correct payments for inappropriate claims within 30 days.*

*Trends are monitored to identify systemic errors which are corrected in collaboration with the MMIS contractor if necessary and, with the contractor who supports HCSIS, if applicable. Remediation is expected within 30 days.*

*Eligibility information entered into the system incorrectly is corrected and the universe of paid claims that was processed using the incorrect information is identified. In the rare event that an overpayment is made, ODP will immediately notify the provider and credit any overpayment on the next PROMISe billing cycle. Thus the FMAP amount charged via the MMIS system to CMS is rapidly corrected, generally within one month or less after an overpayment is discovered. If an underpayment is made, the provider is contacted to void and resubmit in order to obtain the increased rate.*

*FA3 - Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. If a problem is identified, outreach is conducted with the provider and appropriate corrective action is conducted in a timely manner. Providers are expected to correct payments for inappropriate claims within 30 days.*

*Trends are monitored to identify systemic errors which are corrected in collaboration with the MMIS contractor if necessary and, with the contractor who supports HCSIS, if applicable. Remediation is expected within 30 days.*

*Rates entered into the system incorrectly are corrected and the universe of paid claims that was processed using the incorrect information is identified. In the rare event that an overpayment is made, ODP will immediately notify the provider and credit any overpayment on the next PROMISe billing cycle. Thus the FMAP amount charged via the MMIS system to CMS is rapidly corrected, generally within one month or less after an overpayment is discovered. If an underpayment is made, the provider is contacted to void and resubmit in order to obtain the increased rate.*

*FA4 - Percent of waiver claims paid using rates that follow the rate methodology in the approved waiver application. In the rare event that a rate is entered into the MMIS incorrectly, the error will be corrected and the universe of paid claims that was processed using the incorrect information is identified. If the error resulted in overpayment, ODP will immediately notify the provider and credit any overpayment on the next PROMISe billing cycle. Thus the FMAP amount charged via the MMIS to CMS is rapidly corrected, generally within one month or less after an overpayment is discovered. If the error resulted in an underpayment, the provider is contacted to void and resubmit the impacted claims in order to obtain the appropriate 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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☒ ***Other***<br>*Specify:*<br>*Every 6 months* |

***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).*

*There are several approaches to set rates under the PPS, depending on the type of service: fee schedule rates, cost-based rates, payment for vendor goods and services, and participant-directed service rates. For the purposes of this waiver, vendor goods and services refers to payment for the completion of a task or delivery of an item.*

*1. Medical Assistance (MA) Fee Schedule: Services are identified by ODP for placement on the fee schedule prior to July 1 of each year.*
*MA Fee Schedule rates are developed using a market-based approach. This process includes a review of the service definitions & a determination of allowable cost components which reflect costs that are reasonable, necessary & related to the delivery of the service, as defined in Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (OMB Circular Uniform Guidance, 12/26/14). The Department establishes the fee schedule rates to fund services at a level sufficient to ensure access, encourage provider participation & promote provider choice, while at the same time ensuring cost effectiveness and fiscal accountability. The fee schedule rates represent the maximum rates that the Department will pay for each service. In developing MA fee schedule rates, the following occurs:*

**ODP evaluates & uses various independent data sources such as a Pennsylvania-specific compensation study & data from prior approved cost reports, as applicable, & considers the expected expenses for the delivery of the services for the major allowable cost categories listed below:*
*- Support needs of the participants*
*- Staff wages*
*- Staff-related expenses*
*- Productivity*
*- Occupancy*
*- Program expenses & administration-related expenses*
*- A review of approved service definitions & determinations made about cost components that reflect costs necessary & related to the delivery of each service*
*- A review of the cost of implementing Federal, State and local statutes, regulations and ordinances.*

**One MA fee schedule rate is developed for each service and is adjusted by geographical area factors to reflect consideration for differences in wages observed across Pennsylvania. ODP uses independent data sources to analysis the wages.*

**ODP established a variance process for services as stipulated in the service definition in Appendix C when a participant's needs require higher staffing levels or higher trained staff.*

**Rates for the following services and components of a service are on the MA fee schedule: Behavioral Support; Physical Therapy; Occupational Therapy; Speech/Language Therapy; Visual/Mobility Therapy; Shift Nursing; Companion; Supports Broker; In-Home and Community Support; Supported Employment; Respite (excluding respite camp); Small Group Employment; Homemaker/Chore; Advanced Supported Employment; Community Participation Support; Music, Art and Equine Assisted Therapy; Benefits Counseling; Communication Specialist; Consultative Nutritional Services; Housing Transition and Tenancy services; Family/Caregiver Training and Support (excluding training registration and fees); and Supports Coordination. The rate for the on-call and remote support component of Community Participation Support follows the fee schedule rate setting methodology described in this section. The assumptions used to develop the on-call and remote support fee schedule rate included a 1:15 participant to staff ratio and a 0% absentee factor.*

**Each year additional services are considered for the fee schedule. The waiver will be amended prospectively when additional services are added to the fee schedule contingent upon approval from CMS.*

**Changes & addition of services to the fee schedule are communicated through a public notice published in the Pennsylvania Bulletin prior to the effective date of any change or addition. Fee schedule rates are implemented prospectively.*

**ODP will complete studies of the costs associated with the provision of services and the assumptions used to make the rate determinations in timeframes compliant with applicable state regulations and no later than the renewal of the waiver (7/1/22).*

*2. Cost-Based: The cost-based rates are developed in accordance with Department standards in 55 Pa. Code Chapter*

*6100 as follows:*
**Cost and utilization data is collected using a standardized cost report as prepared and submitted by providers of service. Cost reports undergo a desk review in which the reported data is analyzed by ODP or its designee for completeness & accuracy based on cost report instructions & standardized review procedures.*
**Cost report data is adjusted to reflect changes in the service definitions, if necessary, to account for differences in service definitions between the historical reporting period and the period in which the rates will be in effect.*

** Providers who do not submit a cost report, do not successfully submit a cost report that is approved by ODP, or fail to submit an audit are assigned rates by ODP. New providers or current providers who offer new services (defined as providers that enroll and qualify to provide a new service after the cost report process is complete for that period and have no cost history) will also be assigned a rate by ODP. ODP assigns rates in the following manner:*

*-A provider is assigned the provider's cost-based rates for an existing service at a new service location if the provider has an approved cost-based rate at another service location. A provider shall be assigned the state-set rates for new services if:*
*(1) The cost report of the provider did not contain the new service because the service was not delivered during the reporting period.*
*(2) A provider is a new provider who was not delivering services during the reporting period of the cost report.*

**For providers whose cost reports are approved, the cost report data undergoes a review conducted by ODP or their designee. The review includes identifying outliers using a standardized set of criteria for all services with sufficient data points. For outliers, ODP conducts analysis to determine whether adjustments are needed to address variation among providers' unit costs.*

**Since the cost report data is from a historical time period, a Cost of Living Adjustment(COLA) is applied as appropriated by the General Assembly.*

** Prior to the effective date of the rates, the methodology for calculating rates, including a description of the outlier review and rate assignment processes are communicated to the provider in the provider rate notice and in a public notice published in the Pennsylvania Bulletin. Cost report rates are implemented prospectively.*

**The individual provider rate notice includes information on the process to contact ODP on questions and concerns related to the provider rate notice. Providers have the right to appeal as outlined in 55 Pa. Code Chapter 41. The appeal language is included in the provider rate notice.*

**Providers meeting the criteria for audit submission outlined in I-2 are required to submit their Audited Financial Statements to ODP for review. ODP may require resubmission of the cost report if there are material differences between the independent audit and the approved cost report filed by the provider. ODP may also conduct additional audits of providers' costs reports. ODP may recalculate rates for providers who have material differences between their approved & resubmitted cost reports.*

**ODP has a process in place to allow for additional staffing costs above what is included in the approved cost report rate if there is a new participant entering the program that has above average staffing needs.*

*Transportation providers are both private & local government agency providers. Effective 1/1/18, transportation (per trip) will be the only service remaining that utilizes the cost-based methodology.*

*3. Payment for vendor goods and services:*

**ODP reimburses vendor goods and services based on the cost charged to the general public for the good or services. Services reimbursed under vendor goods and services are: Home and Vehicle Accessibility Adaptations, Assistive Technology, Specialized Supplies, Education Support, Public Transportation, Family/Caregiver Training and Support - registration and fees, Participant Directed Goods and Services and Respite Camp.*

**Vendor goods and services must be the most cost-effective to meet the participant's need(s) using a system of competitive bidding or written estimates or the market price of comparable goods or services available in the provider's region. To ensure cost-effectiveness and compliance with the service definition, the SC and service plan team review the*

*bids prior to putting the vendor good or service onto the service plan. The AE also reviews the bids prior to authorizing and approving the service plan. Finally, ODP's QA&I process monitors vendor goods and services to ensure that bids are competitive and cost-efficient.*

**Transportation Mile is reimbursed at the established rate for employees of the Department for business travel.*

*4. Participant-directed service (PDS) rates: Rates for PDS are established through the development of standard wage ranges (which apply to both Vendor Fiscal/Employer Agent [VF/EA] and Agency with Choice [AWC] models) and a fee schedule (AWC model). Effective 7/1/19 Transportation Trip is available thought both VF/EA and AWC models and will be reimbursed through a fee schedule rate.*

**ODP establishes the VF/EA wage ranges by evaluating various data sources, such as a Pennsylvania-specific compensation study.*

**ODP establishes wage ranges and fee schedule for AWC rates. ODP also establishes fee schedule rates for Transportation Trip zones. The fee schedule rate development for AWC and Transportation Trip zones follows the same process as that outlined previously in this section for non-participant directed fee schedule services.*

**Effective 7/1/17 rates for the following services or components of a service are developed consistent with the participant-directed methodologies described above: Homemaker/Chore, Supports Broker, Companion, Supported Employment, In-Home and Community Support and Unlicensed Respite. If the participant chooses to self-direct some or all of these needed services, he or she will utilize the current Vendor Fiscal/Employer Agent or Agency With Choice wage range communication issue by ODP. If the participant chooses not to self-direct any of these services, the MA Fee Schedule rate will be utilized.*

*The VF/EA and AWC wage ranges are issued by ODP prior to July 1 each year in a standard ODP communication. In addition, the AWC Medical Assistance fee schedule rates are communicated prior to July 1 each year through a public notice published in the Pennsylvania Bulletin. Wage ranges and fee schedule rates, when applicable, are implemented prospectively.*

*Claims are processed through PROMISe which is administered by the Office of Medical Assistance Programs (OMAP) and the Department's Bureau of Information Systems (BIS). Claims and payments are monitored by ODP and Administrative Entities (AEs) through the use of PROMISe and HCSIS generated reports.*

*In the future, ODP may use a variety of mechanisms to obtain public comment on rate determination methodologies, including, but not limited to stakeholder workgroup discussions, draft documents distributed for public comment, communications and public meetings.*

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

*All waiver providers, including cost based and fee schedule providers, vendors, FMS providers and Organized Health Care Delivery System (OHCDS) providers that sign a provider agreement or contract with ODP bill through the PROMISe system and are paid by the state Treasury. For participant-directed services, timesheets are submitted to the FMS organization for qualified support service professionals. The FMS is then responsible for billing these services through the PROMISe system. For vendor services provided through participant direction or an OHCDS provider, the invoice is submitted to the FMS organization or OHCDS provider. The FMS organization or OHCDS provider is responsible for billing the vendor service through the PROMISe system.*

## *Appendix I: Financial Accountability*

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

**c. Certifying Public Expenditures** *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

***Select at least one:***

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

*Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

*Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)*

## *Appendix I: Financial Accountability*

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

***d. Billing Validation Process.*** *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

*Provider billings are verified through PROMISe. PROMISe includes edits to determine if the participant is eligible for Medicaid payment on the date of service and ensure that the service was part of the participant's plan. The service is approved for payment by PROMISe only if the service is authorized and there are sufficient units available on the participant's support plan. Validation that the service has been provided occurs through the audit process at the end of the year.*

***e. Billing and Claims Record Maintenance Requirement.*** *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (1 of 7)*

***a. Method of payments -- MMIS*** *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

*Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:*

○ ***Payments for waiver services are not made through an approved MMIS.***

*Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:*

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

*Describe how payments are made to the managed care entity or entities:*

## *Appendix I: Financial Accountability*

### *I-3: Payment (2 of 7)*

***b. Direct payment.*** *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

*Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:*

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

*Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.*

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

*Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.*

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to state or Local Government Providers.** *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ( ) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- (●) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

*Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:*

*Supports Coordination Organizations are either private businesses or businesses run by a county that may receive payment for waiver funded supports coordination services. The provider qualification requirements for Supports Coordination Organizations states that the organization must function as a conflict free entity. A conflict-free Supports Coordination Organization, for purposes of providing supports coordination, is an independent, separate, or self-contained agency that does not have a fiduciary relationship with an agency providing direct services and is not part of a larger corporation. To be conflict free, an Supports Coordination Organization may not provide direct services to participants. The Supports Coordination Organization may also not provide indirect services to participants except that Supports Coordination Organizations may function as an Organized Health Care Delivery System for vendor goods and services. A participant's Supports Coordination Organization may not own or operate providers of vendor goods and services with which it is acting as an Organized Health Care Delivery System.*

*ODP makes payments for supports coordination services based on rates established by the process outlined in Appendix I-2-a Rate Determination Methods, at which time reasonable costs are taken into consideration. Further, ODP's fiscal regulations describe allowable costs and specifically state that the costs for services must "be reasonable for the performance of the HCBS" and "consistent with policies and procedures that apply uniformly to both Federally-funded and other activities of the organization" (55 Pa. Code, Chapter 51.81 (d)).*

## 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:*

*To render vendor goods and services to participants, providers have three options: 1) they may choose to enroll directly with ODP; 2) they may choose to subcontract with an OHCDS for participants who do not self-direct the service(s); or 3) they may be qualified and receive payment through a FMS organization for participants who self-direct their services. Providers are not mandated to render vendor services through an OHCDS.*

*OHCDS providers must meet the following criteria:*
*• Enroll in PROMISe as a provider of P/FDS Waiver services;*

*• Render at least one direct waiver service;*

*• Enter the direct waiver service(s) along with the vendor goods and service(s) they will offer as an OHCDS in HCSIS;*

*• Successfully complete the Provider Qualifications module in HCSIS for the direct waiver service(s) as well as the vendor service(s) they provide and ensure the requirements of Appendix C, including provider qualification standards, are met;*

*• Enter into a Provider Agreement for Participation in Pennsylvania's P/FDS Waiver with ODP;*

*• Submit a bill through PROMISe for either the amount of the vendor good or service that is charged to the general public. See the last paragraph of this section for additional requirements related to payment for vendor services;*

*• Cooperate with the Quality Assessment and Improvement (QA&I) process conducted by ODP or one of its designees, and ensure the subcontracted vendor cooperates with such monitoring when needed or requested;*

*• Cooperate with other monitoring activities, such as Supports Coordination monitoring, and ensure the vendor cooperates with such monitoring;*

*• Comply with regulatory requirements in 55 Pa. Code Chapter 51 or its regulatory successor; and*

*• Maintain documentation on service delivery.*

*Providers that choose to enroll directly with ODP and not deliver a service through an OHCDS must meet the following criteria:*
*• Enroll in PROMISe as a provider of P/FDS Waiver services;*

*• Enter the vendor service(s) they will offer in HCSIS;*

*• Successfully complete the Provider Qualifications module in HCSIS for the vendor service(s) they provide and ensure the requirements of Appendix C, including provider qualification standards, are met;*

*• Enter into a Provider Agreement for Participation in Pennsylvania's P/FDS Waiver with ODP;*

*• Submit a bill through PROMISe for the amount of the vendor good or service that is charged to the general public;*

*• Cooperate with the QA&I process conducted by ODP or one of its designees;*

*• Cooperate with other monitoring activities, such as when Supports Coordinators conduct monitoring visits with participants; and*

*• Maintain documentation on service delivery.*

*Participants are provided with information on willing and qualified providers, as outlined in Appendix D-1-f. This information includes the providers identified in the ODP Services and Support Directory (SSD) for*

*services needed by the participant. The SSD includes both providers that function as an OHCDS and those that are directly enrolled to provide vendor services. The participant is free to choose among the willing and qualified providers, including OHCDS and vendors. The SSD does not differentiate between providers functioning as an OHCDS and those that do not.*

*The OHCDS is responsible to ensure that all subcontracted entities that will render the vendor service(s) meet the qualification criteria specified for the service.*

*Administrative Entities (AEs) are required to complete monitoring of all Waiver providers in accordance with this Waiver and as per ODP policies and procedures. The monitoring is required to be conducted to ensure ongoing compliance with the providers outlined in the current ODP/Provider Agreement, applicable licensing requirements, and written policies and procedures. The monitoring must include a review of compliance with applicable provider qualification standards for all services for which the provider is enrolled and qualified to render.*

*The AE Operating Agreement requires AEs, as part of provider monitoring, to review OHCDS contracts with vendors to ensure they meet applicable state and federal requirements.*

*The cost of the vendor good or service must be the same cost charged to the general (or self-paying) public. The cost of the good must be verified by the AE. Prior to authorizing the service, the AE will verify that the cost of the vendor rate for goods or services does not exceed the rate charged to the general public.*

***iii. Contracts with MCOs, PIHPs or PAHPs.***

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

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

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  *In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

***a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.*** *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

*If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

☐ ***Other State Level Source(s) of Funds.***

*Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

***b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.*** *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

*Check each that applies:*

☐ ***Appropriation of Local Government Revenues.***

*Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:*

☐ ***Other Local Government Level Source(s) of Funds.***

*Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:*

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

***c. Information Concerning Certain Sources of Funds.*** *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  *Check each that applies:*

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  *For each source of funds indicated above, describe the source of the funds in detail:*

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

***a. Services Furnished in Residential Settings.*** *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

***b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.*** *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

*When Respite is provided in an unlicensed residential setting room and board is excluded from the Medicaid payment to the provider.*

## 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* | | *11262.00* | *11262.00* | *215818.00* | *8883.00* | *224701.00* | *213439.00* |
| *2* | | *12402.00* | *12402.00* | *221337.00* | *10958.00* | *232295.00* | *219893.00* |
| *3* | | *12402.00* | *12402.00* | *221337.00* | *10958.00* | *232295.00* | *219893.00* |
| *4* | | *12402.00* | *12402.00* | *221337.00* | *10958.00* | *232295.00* | *219893.00* |
| *5* | | *12402.00* | *12402.00* | *221337.00* | *10958.00* | *232295.00* | *219893.00* |

## *Appendix J: Cost Neutrality Demonstration*

### J-2: Derivation of Estimates (1 of 9)

**a. Number Of Unduplicated Participants Served.** *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

**Table: J-2-a: Unduplicated Participants**

| Waiver Year | Total Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |
|---|---|---|
| | | Level of Care: |
| | | ICF/IID |
| Year 1 | 15490 | 15490 |
| Year 2 | 15490 | 15490 |
| Year 3 | 15490 | 15490 |
| Year 4 | 15490 | 15490 |
| Year 5 | 15490 | 15490 |

## Appendix J: Cost Neutrality Demonstration

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

**b. Average Length of Stay.** *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

*The Office of Developmental Programs (ODP) based the average length of stay (ALOS) on historical enrollment information, utilization and user counts for the Waiver. Based upon recent trends ODP found that the ALOS does not vary significantly from year to year, even with the change in participants with newly enrolled individuals. Therefore, the estimated 332 days is consistent with historical experience and not expected to change in the projection years.*

## Appendix J: Cost Neutrality Demonstration

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

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

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

*Factor D for Year 1 was based on FY 16-17 cost used for the completion of the 372 Report, current rates, utilization and budget authority. Factor D for Years 2, 3, 4, and 5 is based on FY 18-19 cost used for the completion of the 372 Report current rates, utilization and budget authority.*

*Though historical experience would suggest rising rates and utilization per user, ODP anticipates that efforts to continue to enhance the plan development, service definition changes and authorization practices across the Commonwealth will have a stabilizing impact on overall expenditures. Pennsylvania's legislature approves funding on an annual basis. ODP develops a budget request on an annual basis and operates within the approved budget.*

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

*Factor D' for Year 1 was based on FY 16-17 cost used for the completion of the 372 Report, current rates, utilization and budget authority. Factor D' for Years 2, 3, 4, and 5 is based on FY 18-19 cost used for the completion of the 372 Report current rates, utilization and budget authority. It represents the average per participant non-waiver state plan service costs.*

*Pennsylvania's legislature approves funding on an annual basis. ODP develops a budget request on an annual basis and operates within the approved budget.*

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

*Factor G for Year 1 was based on FY 16-17 cost used for the completion of the 372 Report, current rates, utilization and budget authority. Factor G for Years 2, 3, 4, and 5 is based on FY 18-19 cost used for the completion of the 372 Report current rates, utilization and budget authority. It represents the ICF/ID and state center expenditures and users.*

*Pennsylvania's legislature approves funding on an annual basis. ODP develops a budget request on an annual basis and operates within the approved budget.*

*The number of individuals in Intermediate Care Facilities continues to decrease each year, however, the costs to serve those individuals that remain in these facilities do not decline with the census. This is due to the fact that 1) many of the costs are fixed regardless of the census in the facility; 2) the individuals in the facilities are aging and require increased care; and 3) the few individuals who are admitted each year have higher acuity levels and need intensive staffing.*

***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:*

*Factor G' for Year 1 was based on FY 16-17 cost used for the completion of the 372 Report, current rates, utilization and budget authority. Factor G' for Years 2, 3, 4, and 5 is based on FY 18-19 cost used for the completion of the 372 Report current rates, utilization and budget authority. It represents the average cost per recipient for non-institutional state plan services provided to individuals in the ICF/ID program and state centers.*

*Pennsylvania's legislature approves funding on an annual basis. ODP develops a budget request on an annual basis and operates within the approved budget.*

## *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* | |
|---|---|
| *Community Participation Support* | |
| *Education Support Services* | |
| *Family Medical Support Assistance* | |
| *Homemaker/Chore* | |
| *In-Home and Community Support* | |
| *Respite* | |
| *Supported Employment* | |
| *Supports Coordination* | |
| *Specialized Supplies* | |
| *Therapy Services* | |
| *Supports Broker Services* | |

| Waiver Services | |
|---|---|
| Advanced Supported Employment | |
| Assistive Technology | |
| Behavioral Support | |
| Benefits Counseling | |
| Communication Specialist Services | |
| Companion | |
| Consultative Nutritional Services | |
| Family Medical Support Assistance | |
| Family/Caregiver Training and Support | |
| Home Accessibility Adaptations | |
| Housing Transition and Tenancy Sustaining Service | |
| Music Therapy, Art Therapy and Equine Assisted Therapy | |
| Participant-Directed Goods and Services | |
| Shift Nursing | |
| Small Group Employment | |
| Transportation | |
| Vehicle Accessibility Adaptations | |

## 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 |
|---|---|---|---|---|---|---|
| Community Participation Support Total: | | | | | | 120793530.00 |
| Base | 15 minutes | 2940 | 2640.00 | 4.86 | 37721376.00 | |
| Level 1 | 15 minutes | 800 | 2670.00 | 4.81 | 10274160.00 | |
| Level 2 | 15 minutes | 5800 | 1877.00 | 6.34 | 69021044.00 | |
| Level 3 | 15 minutes | 275 | 865.00 | 11.79 | 2804546.25 | |
| Level 4 | 15 minutes | 5 | 143.00 | 20.53 | 14678.95 | |
| Older Adult Living | 15 minutes | 120 | 2978.00 | 2.68 | 957724.80 | |
| | | | | GRAND TOTAL: | | |
| | | | | Total Estimated Unduplicated Participants: | | 15490 |
| | | | | Factor D (Divide total by number of participants): | | |
| | | | | Average Length of Stay on the Waiver: | | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| On-Call and Remote Support | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Remote CPS Service 1:1-1:5 | 15 minutes | 0 | 0.00 | 4.94 | 0.00 | |
| Remote CPS Services 1:6 and above | 15 minutes | 0 | 0.00 | 1.91 | 0.00 | |
| **Education Support Services Total:** | | | | | | 678348.00 |
| Education Support Services | Vendor Goods and | 66 | 2284.00 | 4.50 | 678348.00 | |
| **Family Medical Support Assistance Total:** | | | | | | |
| Family Medical Support Assistance | | | | | | |
| **Homemaker/Chore Total:** | | | | | | 164924.34 |
| Homemaker/Chore | Hour | 93 | 106.00 | 16.73 | 164924.34 | |
| **In-Home and Community Support Total:** | | | | | | 105208680.62 |
| Base (1:3) | 15 minutes | 590 | 601.00 | 3.17 | 1124050.30 | |
| Level 1 (1:2) | 15 minutes | 800 | 500.00 | 4.52 | 1808000.00 | |
| Level 2 (1:1) | 15 minutes | 8556 | 1434.00 | 8.08 | 99135976.32 | |
| Level 2L (1:1 with license) | 15 minutes | 350 | 697.00 | 11.44 | 2790788.00 | |
| Level 3 (2:1) | 15 minutes | 25 | 701.00 | 15.72 | 275493.00 | |
| Level 3L (2:1 with license) | 15 minutes | 10 | 390.00 | 19.07 | 74373.00 | |
| **Respite Total:** | | | | | | 5590657.16 |
| Base - 15 min (1:4) | 15 minutes | 11 | 261.00 | 1.74 | 4995.54 | |
| Base - Day (1:4) | Day | 29 | 4.00 | 69.55 | 8067.80 | |
| Level 1 - 15 min (1:3) | 15 minutes | 37 | 228.00 | 2.32 | 19571.52 | |
| Level 1 - Day (1:3) | Day | 36 | 7.00 | 92.69 | 23357.88 | |
| Level 2 - 15 min (1:2) | 15 minutes | 38 | 171.00 | 3.47 | 22548.06 | |
| Level 2 - Day (1:2) | | | | | 33070.10 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 15490 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Day | 34 | 7.00 | 138.95 | | |
| Level 3 - 15 min (1:1) | 15 minutes | 1000 | 298.00 | 6.20 | 1847600.00 | |
| Level 3 - Day (1:1) | Day | 662 | 9.00 | 248.02 | 1477703.16 | |
| Level 4 - 15 min (2:1) | 15 minutes | 2 | 2.00 | 12.40 | 49.60 | |
| Level 4 - Day (2:1) | Day | 1 | 20.00 | 495.87 | 9917.40 | |
| Licensed - 1 Person - Day | Day | 6 | 11.00 | 700.00 | 46200.00 | |
| Licensed - 2 Person - Day | Day | 37 | 13.00 | 650.00 | 312650.00 | |
| Licensed - 3 Person - Day | Day | 45 | 15.00 | 450.00 | 303750.00 | |
| Licensed - 4 Person - Day | Day | 74 | 13.00 | 350.00 | 336700.00 | |
| Respite - Camp - 15 minutes | 15 minutes | 275 | 180.00 | 3.85 | 190575.00 | |
| Respite - Camp - Day | Day | 675 | 6.00 | 175.00 | 708750.00 | |
| Level 3L - 15 min (1:1 with license) | 15 minutes | 30 | 471.00 | 10.42 | 147234.60 | |
| Level 3L - Day (1:1 with license) | Day | 20 | 10.00 | 416.93 | 83386.00 | |
| Level 4L - 15 min (2:1 with license) | 15 minutes | 2 | 239.00 | 16.55 | 7910.90 | |
| Level 4L - Day (2:1 with license) | Day | 2 | 5.00 | 661.96 | 6619.60 | |
| **Supported Employment Total:** | | | | | | 11959593.75 |
| Career Assessment | 15 minutes | 147 | 263.00 | 17.75 | 686232.75 | |
| Job Finding and Development | 15 minutes | 454 | 256.00 | 17.75 | 2062976.00 | |
| Job Coaching and Support - Base (1:2 to 1:4) | 15 minutes | 7 | 470.00 | 10.45 | 34380.50 | |
| Job Coaching and Support - Level 1 (1:1) | 15 minutes | 1534 | 337.00 | 17.75 | 9176004.50 | |
| **Supports Coordination Total:** | | | | | | 35680277.52 |
| Supports Coordination | 15 minutes | 13987 | 108.00 | 23.62 | 35680277.52 | |
| **Specialized Supplies Total:** | | | | | | 4760.00 |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 15490 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Specialized Supplies | Vendor Goods and | 17 | 56.00 | 5.00 | 4760.00 | |
| **Therapy Services Total:** | | | | | | 25930.80 |
| Physical Therapy | 15 minutes | 4 | 9.00 | 21.29 | 766.44 | |
| Occupational Therapy | 15 minutes | 4 | 1.00 | 19.71 | 78.84 | |
| Speech/Language Therapy | 15 minutes | 8 | 162.00 | 19.12 | 24779.52 | |
| Orientation, Mobility and Vision Therapy | 15 minutes | 5 | 3.37 | 18.16 | 306.00 | |
| **Supports Broker Services Total:** | | | | | | 301814.40 |
| Supports Broker Services | 15 minutes | 60 | 298.00 | 16.88 | 301814.40 | |
| **Advanced Supported Employment Total:** | | | | | | 23462.84 |
| Advanced Supported Employment | Outcome Based Units | 4 | 1.00 | 5865.71 | 23462.84 | |
| **Assistive Technology Total:** | | | | | | 155800.00 |
| Assistive Technology | Vendor Goods and | 41 | 19.00 | 200.00 | 155800.00 | |
| **Behavioral Support Total:** | | | | | | 4063931.79 |
| Level 1 | 15 minutes | 1069 | 180.00 | 21.12 | 4063910.40 | |
| Level 2 | 15 minutes | 1 | 1.00 | 21.39 | 21.39 | |
| **Benefits Counseling Total:** | | | | | | 4332.00 |
| Benefits Counseling | 15 minutes | 10 | 38.00 | 11.40 | 4332.00 | |
| **Communication Specialist Services Total:** | | | | | | 15.32 |
| Communications Specialist Services | 15 minutes | 1 | 1.00 | 15.32 | 15.32 | |
| **Companion Total:** | | | | | | 25074495.52 |
| Base (1:3) | 15 minutes | 72 | 762.00 | 2.64 | 144840.96 | |
| Level 1 (1:2) | 15 minutes | 40 | 1232.80 | 3.67 | 180975.04 | |
| Level 2 (1:1) | 15 minutes | 2736 | 1429.00 | 6.33 | 24748679.52 | |
| **Consultative** | | | | | | 12.36 |

| | | |
|---|---|---|
| **GRAND TOTAL:** | | |
| **Total Estimated Unduplicated Participants:** | | 15490 |
| **Factor D (Divide total by number of participants):** | | |
| **Average Length of Stay on the Waiver:** | 332 | |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Nutritional Services Total:** | | | | | | |
| Consultative Nutritional Services | 15 minutes | 1 | 1.00 | 12.36 | **12.36** | |
| **Family Medical Support Assistance Total:** | | | | | | **0.00** |
| Family Medical Support Assistance | 15 minutes | 0 | 0.00 | 18.41 | **0.00** | |
| **Family/Caregiver Training and Support Total:** | | | | | | **353.03** |
| Direct Training & Support | 15 minutes | 1 | 1.00 | 12.12 | **12.12** | |
| Training Registration & Fees | Vendor Goods and | 1 | 1.00 | 340.91 | **340.91** | |
| **Home Accessibility Adaptations Total:** | | | | | | **427828.50** |
| Home Accessibility Adaptations | Vendor Goods and | 67 | 473.00 | 13.50 | **427828.50** | |
| **Housing Transition and Tenancy Sustaining Service Total:** | | | | | | **10.94** |
| Housing Transition Services | 15 minutes | 1 | 1.00 | 10.94 | **10.94** | |
| **Music Therapy, Art Therapy and Equine Assisted Therapy Total:** | | | | | | **20042.00** |
| Music Therapy | 15 minutes | 10 | 40.00 | 15.34 | **6136.00** | |
| Art Therapy | 15 minutes | 10 | 40.00 | 15.34 | **6136.00** | |
| Equine Therapy | 15 minutes | 15 | 50.00 | 10.36 | **7770.00** | |
| **Participant-Directed Goods and Services Total:** | | | | | | **3000.00** |
| Participant Directed Goods & Serv. | Vendor Goods and | 3 | 4.00 | 250.00 | **3000.00** | |
| **Shift Nursing Total:** | | | | | | **248220.00** |
| Shift Nursing | 15 minutes | 35 | 788.00 | 9.00 | **248220.00** | |
| **Small Group Employment Total:** | | | | | | **4840961.99** |
| Base | 15 minutes | 103 | 1823.00 | 2.29 | **429991.01** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **15490** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Level 1 | 15 minutes | 300 | 1777.00 | 3.52 | 1876512.00 | |
| Level 2 | 15 minutes | 285 | 1110.00 | 6.83 | 2160670.50 | |
| Level 3 | 15 minutes | 61 | 491.00 | 12.48 | 373788.48 | |
| **Transportation Total:** | | | | | | 25198314.40 |
| Public Transportation | Vendor Goods and | 4786 | 350.00 | 4.50 | 7537950.00 | |
| Transportation (Trip) | Trip | 3234 | 241.00 | 20.00 | 15587880.00 | |
| Transportation (Mile) | Mile | 1435 | 2579.00 | 0.56 | 2072484.40 | |
| **Vehicle Accessibility Adaptations Total:** | | | | | | 65000.00 |
| Vehicle Accessibility Adaptations | Vendor Goods and | 13 | 1.00 | 5000.00 | 65000.00 | |
| | | | | **GRAND TOTAL:** | | |
| | | | | **Total Estimated Unduplicated Participants:** | | 15490 |
| | | | | **Factor D (Divide total by number of participants):** | | |
| | | | | **Average Length of Stay on the Waiver:** | | 332 |

## *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 |
|---|---|---|---|---|---|---|
| **Community Participation Support Total:** | | | | | | 120793530.00 |
| Base | 15 minutes | 2940 | 2640.00 | 4.86 | 37721376.00 | |
| Level 1 | 15 minutes | 800 | 2670.00 | 4.81 | 10274160.00 | |
| Level 2 | 15 minutes | 5800 | 1877.00 | 6.34 | 69021044.00 | |
| Level 3 | 15 minutes | 275 | 865.00 | 11.79 | 2804546.25 | |
| | | | | **GRAND TOTAL:** | | |
| | | | | **Total Estimated Unduplicated Participants:** | | 15490 |
| | | | | **Factor D (Divide total by number of participants):** | | |
| | | | | **Average Length of Stay on the Waiver:** | | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Level 4 | 15 minutes | 5 | 143.00 | 20.53 | 14678.95 | |
| Older Adult Living | 15 minutes | 120 | 2978.00 | 2.68 | 957724.80 | |
| On-Call and Remote Support | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Remote CPS Service 1:1-1:5 | 15 minutes | 0 | 0.00 | 4.94 | 0.00 | |
| Remote CPS Services 1:6 and above | 15 minutes | 0 | 0.00 | 1.91 | 0.00 | |
| **Education Support Services Total:** | | | | | | 678348.00 |
| Education Support Services | Vendor Goods and | 66 | 2284.00 | 4.50 | 678348.00 | |
| **Family Medical Support Assistance Total:** | | | | | | |
| Family Medical Support Assistance | | | | | | |
| **Homemaker/Chore Total:** | | | | | | 164924.34 |
| Homemaker/Chore | Hour | 93 | 106.00 | 16.73 | 164924.34 | |
| **In-Home and Community Support Total:** | | | | | | 105208680.62 |
| Base (1:3) | 15 minutes | 590 | 601.00 | 3.17 | 1124050.30 | |
| Level 1 (1:2) | 15 minutes | 800 | 500.00 | 4.52 | 1808000.00 | |
| Level 2 (1:1) | 15 minutes | 8556 | 1434.00 | 8.08 | 99135976.32 | |
| Level 2L (1:1 with license) | 15 minutes | 350 | 697.00 | 11.44 | 2790788.00 | |
| Level 3 (2:1) | 15 minutes | 25 | 701.00 | 15.72 | 275493.00 | |
| Level 3L (2:1 with license) | 15 minutes | 10 | 390.00 | 19.07 | 74373.00 | |
| **Respite Total:** | | | | | | 5596795.16 |
| Base - 15 min (1:4) | 15 minutes | 11 | 261.00 | 1.74 | 4995.54 | |
| Base - Day (1:4) | Day | 29 | 4.00 | 69.55 | 8067.80 | |
| Level 1 - 15 min (1:3) | 15 minutes | 37 | 228.00 | 2.32 | 19571.52 | |
| Level 1 - Day (1:3) | | | | | 23357.88 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 15490 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Day | 36 | 7.00 | 92.69 | | |
| Level 2 - 15 min (1:2) | 15 minutes | 38 | 171.00 | 3.47 | 22548.06 | |
| Level 2 - Day (1:2) | Day | 34 | 7.00 | 138.95 | 33070.10 | |
| Level 3 - 15 min (1:1) | 15 minutes | 1000 | 298.99 | 6.20 | 1853738.00 | |
| Level 3 - Day (1:1) | Day | 662 | 9.00 | 248.02 | 1477703.16 | |
| Level 4 - 15 min (2:1) | 15 minutes | 2 | 2.00 | 12.40 | 49.60 | |
| Level 4 - Day (2:1) | Day | 1 | 20.00 | 495.87 | 9917.40 | |
| Licensed - 1 Person - Day | Day | 6 | 11.00 | 700.00 | 46200.00 | |
| Licensed - 2 Person - Day | Day | 37 | 13.00 | 650.00 | 312650.00 | |
| Licensed - 3 Person - Day | Day | 45 | 15.00 | 450.00 | 303750.00 | |
| Licensed - 4 Person - Day | Day | 74 | 13.00 | 350.00 | 336700.00 | |
| Respite - Camp - 15 minutes | 15 minutes | 275 | 180.00 | 3.85 | 190575.00 | |
| Respite - Camp - Day | Day | 675 | 6.00 | 175.00 | 708750.00 | |
| Level 3L - 15 min (1:1 with license) | 15 minutes | 30 | 471.00 | 10.42 | 147234.60 | |
| Level 3L - Day (1:1 with license) | Day | 20 | 10.00 | 416.93 | 83386.00 | |
| Level 4L - 15 min (2:1 with license) | 15 minutes | 2 | 239.00 | 16.55 | 7910.90 | |
| Level 4L - Day (2:1 with license) | Day | 2 | 5.00 | 661.96 | 6619.60 | |
| **Supported Employment Total:** | | | | | | 11959593.75 |
| Career Assessment | 15 minutes | 147 | 263.00 | 17.75 | 686232.75 | |
| Job Finding and Development | 15 minutes | 454 | 256.00 | 17.75 | 2062976.00 | |
| Job Coaching and Support - Base (1:2 to 1:4) | 15 minutes | 7 | 470.00 | 10.45 | 34380.50 | |
| Job Coaching and Support - Level 1 (1:1) | 15 minutes | 1534 | 337.00 | 17.75 | 9176004.50 | |
| **Supports Coordination Total:** | | | | | | 35680277.52 |

| | | |
|---|---|---|
| **GRAND TOTAL:** | | |
| **Total Estimated Unduplicated Participants:** | | 15490 |
| **Factor D (Divide total by number of participants):** | | |
| **Average Length of Stay on the Waiver:** | 332 | |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Supports Coordination | 15 minutes | 13987 | 108.00 | 23.62 | 35680277.52 | |
| **Specialized Supplies Total:** | | | | | | 4760.00 |
| Specialized Supplies | Vendor Goods and | 17 | 56.00 | 5.00 | 4760.00 | |
| **Therapy Services Total:** | | | | | | 25930.80 |
| Physical Therapy | 15 minutes | 4 | 9.00 | 21.29 | 766.44 | |
| Occupational Therapy | 15 minutes | 4 | 1.00 | 19.71 | 78.84 | |
| Speech/Language Therapy | 15 minutes | 8 | 162.00 | 19.12 | 24779.52 | |
| Orientation, Mobility and Vision Therapy | 15 minutes | 5 | 3.37 | 18.16 | 306.00 | |
| **Supports Broker Services Total:** | | | | | | 301814.40 |
| Supports Broker Services | 15 minutes | 60 | 298.00 | 16.88 | 301814.40 | |
| **Advanced Supported Employment Total:** | | | | | | 23462.84 |
| Advanced Supported Employment | Oucome Based Services | 4 | 1.00 | 5865.71 | 23462.84 | |
| **Assistive Technology Total:** | | | | | | 155800.00 |
| Assistive Technology | Vendor Goods and | 41 | 19.00 | 200.00 | 155800.00 | |
| **Behavioral Support Total:** | | | | | | 4063931.79 |
| Level 1 | 15 minutes | 1069 | 180.00 | 21.12 | 4063910.40 | |
| Level 2 | 15 minutes | 1 | 1.00 | 21.39 | 21.39 | |
| **Benefits Counseling Total:** | | | | | | 4332.00 |
| Benefits Counseling | 15 minutes | 10 | 38.00 | 11.40 | 4332.00 | |
| **Communication Specialist Services Total:** | | | | | | 15.32 |
| Communications Specialist Services | 15 minutes | 1 | 1.00 | 15.32 | 15.32 | |
| **Companion Total:** | | | | | | 25074495.52 |
| Base (1:3) | 15 minutes | 72 | 762.00 | 2.64 | 144840.96 | |
| Level 1 (1:2) | | | | | 180975.04 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 15490 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | 15 minutes | 40 | 1232.80 | 3.67 | | |
| Level 2 (1:1) | 15 minutes | 2736 | 1429.00 | 6.33 | 24748679.52 | |
| **Consultative Nutritional Services Total:** | | | | | | **12.36** |
| Consultative Nutritional Services | 15 minutes | 1 | 1.00 | 12.36 | **12.36** | |
| **Family Medical Support Assistance Total:** | | | | | | **0.00** |
| Family Medical Support Assistance | 15 minutes | 0 | 0.00 | 18.41 | **0.00** | |
| **Family/Caregiver Training and Support Total:** | | | | | | **353.03** |
| Direct Training & Support | 15 minutes | 1 | 1.00 | 12.12 | **12.12** | |
| Training Registration & Fees | Vendor Goods and | 1 | 1.00 | 340.91 | **340.91** | |
| **Home Accessibility Adaptations Total:** | | | | | | **427828.50** |
| Home Accessibility Adaptations | Vendor Goods and | 67 | 473.00 | 13.50 | **427828.50** | |
| **Housing Transition and Tenancy Sustaining Service Total:** | | | | | | **10.94** |
| Housing Transition Services | 15 minutes | 1 | 1.00 | 10.94 | **10.94** | |
| **Music Therapy, Art Therapy and Equine Assisted Therapy Total:** | | | | | | **20042.00** |
| Music Therapy | 15 minutes | 10 | 40.00 | 15.34 | **6136.00** | |
| Art Therapy | 15 minutes | 10 | 40.00 | 15.34 | **6136.00** | |
| Equine Therapy | 15 minutes | 15 | 50.00 | 10.36 | **7770.00** | |
| **Participant-Directed Goods and Services Total:** | | | | | | **3000.00** |
| Participant Directed Goods & Serv. | Vendor Goods and | 3 | 4.00 | 250.00 | **3000.00** | |
| **Shift Nursing Total:** | | | | | | **248220.00** |
| Shift Nursing | 15 minutes | 35 | 788.00 | 9.00 | **248220.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **15490** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Small Group Employment Total:** | | | | | | **4840961.99** |
| Base | 15 minutes | 103 | 1823.00 | 2.29 | **429991.01** | |
| Level 1 | 15 minutes | 300 | 1777.00 | 3.52 | **1876512.00** | |
| Level 2 | 15 minutes | 285 | 1110.00 | 6.83 | **2160670.50** | |
| Level 3 | 15 minutes | 61 | 491.00 | 12.48 | **373788.48** | |
| **Transportation Total:** | | | | | | **25198314.40** |
| Public Transportation | Vendor Goods and | 4786 | 350.00 | 4.50 | **7537950.00** | |
| Transportation (Trip) | Trip | 3234 | 241.00 | 20.00 | **15587880.00** | |
| Transportation (Mile) | Mile | 1435 | 2579.00 | 0.56 | **2072484.40** | |
| **Vehicle Accessibility Adaptations Total:** | | | | | | **65000.00** |
| Vehicle Accessibility Adaptations | Vendor Goods and | 13 | 1.00 | 5000.00 | **65000.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **15490** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

## *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 |
|---|---|---|---|---|---|---|
| **Community Participation Support Total:** | | | | | | **120793530.00** |
| Base | 15 minutes | 2940 | 2640.00 | 4.86 | **37721376.00** | |
| Level 1 | 15 minutes | 800 | 2670.00 | 4.81 | **10274160.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **15490** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Level 2 | 15 minutes | 5800 | 1877.00 | 6.34 | 69021044.00 | |
| Level 3 | 15 minutes | 275 | 865.00 | 11.79 | 2804546.25 | |
| Level 4 | 15 minutes | 5 | 143.00 | 20.53 | 14678.95 | |
| Older Adult Living | 15 minutes | 120 | 2978.00 | 2.68 | 957724.80 | |
| On-Call and Remote Support | 15 minutes | 0 | 0.00 | 1.33 | 0.00 | |
| Remote CPS Service 1:1-1:5 | 15 minutes | 0 | 0.00 | 4.94 | 0.00 | |
| Remote CPS Services 1:6 and above | 15 minutes | 0 | 0.00 | 1.91 | 0.00 | |
| **Education Support Services Total:** | | | | | | 678348.00 |
| Education Support Services | Vendor Goods and | 66 | 2284.00 | 4.50 | 678348.00 | |
| **Family Medical Support Assistance Total:** | | | | | | |
| Family Medical Support Assistance | | | | | | |
| **Homemaker/Chore Total:** | | | | | | 164924.34 |
| Homemaker/Chore | hour | 93 | 106.00 | 16.73 | 164924.34 | |
| **In-Home and Community Support Total:** | | | | | | 105208680.62 |
| Base (1:3) | 15 minutes | 590 | 601.00 | 3.17 | 1124050.30 | |
| Level 1 (1:2) | 15 minutes | 800 | 500.00 | 4.52 | 1808000.00 | |
| Level 2 (1:1) | 15 minutes | 8556 | 1434.00 | 8.08 | 99135976.32 | |
| Level 2L (1:1 with license) | 15 minutes | 350 | 697.00 | 11.44 | 2790788.00 | |
| Level 3 (2:1) | 15 minutes | 25 | 701.00 | 15.72 | 275493.00 | |
| Level 3L (2:1 with license) | 15 minutes | 10 | 390.00 | 19.07 | 74373.00 | |
| **Respite Total:** | | | | | | 5590657.16 |
| Base - 15 min (1:4) | 15 minutes | 11 | 261.00 | 1.74 | 4995.54 | |
| Base - Day (1:4) | | | | | 8067.80 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 15490 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Day | 29 | 4.00 | 69.55 | | |
| Level 1 - 15 min (1:3) | 15 minutes | 37 | 228.00 | 2.32 | 19571.52 | |
| Level 1 - Day (1:3) | Day | 36 | 7.00 | 92.69 | 23357.88 | |
| Level 2 - 15 min (1:2) | 15 minutes | 38 | 171.00 | 3.47 | 22548.06 | |
| Level 2 - Day (1:2) | Day | 34 | 7.00 | 138.95 | 33070.10 | |
| Level 3 - 15 min (1:1) | 15 minutes | 1000 | 298.00 | 6.20 | 1847600.00 | |
| Level 3 - Day (1:1) | Day | 662 | 9.00 | 248.02 | 1477703.16 | |
| Level 4 - 15 min (2:1) | 15 minutes | 2 | 2.00 | 12.40 | 49.60 | |
| Level 4 - Day (2:1) | Day | 1 | 20.00 | 495.87 | 9917.40 | |
| Licensed - 1 Person - Day | Day | 6 | 11.00 | 700.00 | 46200.00 | |
| Licensed - 2 Person - Day | Day | 37 | 13.00 | 650.00 | 312650.00 | |
| Licensed - 3 Person - Day | Day | 45 | 15.00 | 450.00 | 303750.00 | |
| Licensed - 4 Person - Day | Day | 74 | 13.00 | 350.00 | 336700.00 | |
| Respite - Camp - 15 minutes | 15 minutes | 275 | 180.00 | 3.85 | 190575.00 | |
| Respite - Camp - Day | Day | 675 | 6.00 | 175.00 | 708750.00 | |
| Level 3L - 15 min (1:1 with license) | 15 minutes | 30 | 471.00 | 10.42 | 147234.60 | |
| Level 3L - Day (1:1 with license) | Day | 20 | 10.00 | 416.93 | 83386.00 | |
| Level 4L - 15 min (2:1 with license) | 15 minutes | 2 | 239.00 | 16.55 | 7910.90 | |
| Level 4L - Day (2:1 with license) | Day | 2 | 5.00 | 661.96 | 6619.60 | |
| **Supported Employment Total:** | | | | | | 11959593.75 |
| Career Assessment | 15 minutes | 147 | 263.00 | 17.75 | 686232.75 | |
| Job Finding and Development | 15 minutes | 454 | 256.00 | 17.75 | 2062976.00 | |
| Job Coaching and Support - Base | 15 minutes | 7 | 470.00 | 10.45 | 34380.50 | |

| | | |
|---|---|---|
| **GRAND TOTAL:** | | |
| **Total Estimated Unduplicated Participants:** | | 15490 |
| **Factor D (Divide total by number of participants):** | | |
| **Average Length of Stay on the Waiver:** | 332 | |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| (1:2 to 1:4) | | | | | | |
| Job Coaching and Support - Level 1 (1:1) | 15 minutes | 1534 | 337.00 | 17.75 | 9176004.50 | |
| **Supports Coordination Total:** | | | | | | 35680277.52 |
| Supports Coordination | 15 minutes | 13987 | 108.00 | 23.62 | 35680277.52 | |
| **Specialized Supplies Total:** | | | | | | 4760.00 |
| Specialized Supplies | Vendor Goods and | 17 | 56.00 | 5.00 | 4760.00 | |
| **Therapy Services Total:** | | | | | | 25930.80 |
| Physical Therapy | 15 minutes | 4 | 9.00 | 21.29 | 766.44 | |
| Occupational Therapy | 15 minutes | 4 | 1.00 | 19.71 | 78.84 | |
| Speech/Language Therapy | 15 minutes | 8 | 162.00 | 19.12 | 24779.52 | |
| Orientation, Mobility and Vision Therapy | 15 minutes | 5 | 3.37 | 18.16 | 306.00 | |
| **Supports Broker Services Total:** | | | | | | 301814.40 |
| Supports Broker Services | 15 minutes | 60 | 298.00 | 16.88 | 301814.40 | |
| **Advanced Supported Employment Total:** | | | | | | 23462.84 |
| Advanced Supported Employment | 15 minutes | 4 | 1.00 | 5865.71 | 23462.84 | |
| **Assistive Technology Total:** | | | | | | 155800.00 |
| Assistive Technology | Outcome Based Unit | 41 | 19.00 | 200.00 | 155800.00 | |
| **Behavioral Support Total:** | | | | | | 4063931.79 |
| Level 1 | Vendor Goods and | 1069 | 180.00 | 21.12 | 4063910.40 | |
| Level 2 | 15 minutes | 1 | 1.00 | 21.39 | 21.39 | |
| **Benefits Counseling Total:** | | | | | | 4332.00 |
| Benefits Counseling | 15 minutes | 10 | 38.00 | 11.40 | 4332.00 | |
| **Communication Specialist Services Total:** | | | | | | 15.32 |
| Communications Specialist Services | 15 minutes | 1 | 1.00 | 15.32 | 15.32 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 15490 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Companion Total:** | | | | | | **25074495.52** |
| Base (1:3) | 15 minutes | 72 | 762.00 | 2.64 | **144840.96** | |
| Level 1 (1:2) | 15 minutes | 40 | 1232.80 | 3.67 | **180975.04** | |
| Level 2 (1:1) | 15 minutes | 2736 | 1429.00 | 6.33 | **24748679.52** | |
| **Consultative Nutritional Services Total:** | | | | | | **12.36** |
| Consultative Nutritional Services | 15 minutes | 1 | 1.00 | 12.36 | **12.36** | |
| **Family Medical Support Assistance Total:** | | | | | | **0.00** |
| Family Medical Support Assistance | 15 minutes | 0 | 0.00 | 18.41 | **0.00** | |
| **Family/Caregiver Training and Support Total:** | | | | | | **353.03** |
| Direct Training & Support | 15 minutes | 1 | 1.00 | 12.12 | **12.12** | |
| Training Registration & Fees | Vendor Goods and | 1 | 1.00 | 340.91 | **340.91** | |
| **Home Accessibility Adaptations Total:** | | | | | | **427828.50** |
| Home Accessibility Adaptations | Vendor Goods and | 67 | 473.00 | 13.50 | **427828.50** | |
| **Housing Transition and Tenancy Sustaining Service Total:** | | | | | | **10.94** |
| Housing Transition Services | Vendor Goods and | 1 | 1.00 | 10.94 | **10.94** | |
| **Music Therapy, Art Therapy and Equine Assisted Therapy Total:** | | | | | | **20042.00** |
| Music Therapy | 15 minutes | 10 | 40.00 | 15.34 | **6136.00** | |
| Art Therapy | 15 minutes | 10 | 40.00 | 15.34 | **6136.00** | |
| Equine Therapy | 15 minutes | 15 | 50.00 | 10.36 | **7770.00** | |
| **Participant-Directed Goods and Services Total:** | | | | | | **3000.00** |
| Participant Directed Goods & | 15 minutes | 3 | 4.00 | 250.00 | **3000.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **15490** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Serv. | | | | | | |
| **Shift Nursing Total:** | | | | | | **248220.00** |
| Shift Nursing | Vendor Goods and | 35 | 788.00 | 9.00 | **248220.00** | |
| **Small Group Employment Total:** | | | | | | **4840961.99** |
| Base | 15 minutes | 103 | 1823.00 | 2.29 | **429991.01** | |
| Level 1 | 15 minutes | 300 | 1777.00 | 3.52 | **1876512.00** | |
| Level 2 | 15 minutes | 285 | 1110.00 | 6.83 | **2160670.50** | |
| Level 3 | 15 minutes | 61 | 491.00 | 12.48 | **373788.48** | |
| **Transportation Total:** | | | | | | **23044614.40** |
| Public Transportation | 15 minutes | 4786 | 250.00 | 4.50 | **5384250.00** | |
| Transportation (Trip) | Trip | 3234 | 241.00 | 20.00 | **15587880.00** | |
| Transportation (Mile) | Vendor Goods and | 1435 | 2579.00 | 0.56 | **2072484.40** | |
| **Vehicle Accessibility Adaptations Total:** | | | | | | **65000.00** |
| Vehicle Accessibility Adaptations | Mile | 13 | 1.00 | 5000.00 | **65000.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **15490** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

## *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 |
|---|---|---|---|---|---|---|
| **Community Participation Support Total:** | | | | | | **120793530.00** |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **15490** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Base | 15 minutes | 2940 | 2640.00 | 4.86 | 37721376.00 | |
| Level 1 | 15 minutes | 800 | 2670.00 | 4.81 | 10274160.00 | |
| Level 2 | 15 minutes | 5800 | 1877.00 | 6.34 | 69021044.00 | |
| Level 3 | 15 minutes | 275 | 865.00 | 11.79 | 2804546.25 | |
| Level 4 | 15 minutes | 5 | 143.00 | 20.53 | 14678.95 | |
| Older Adult Living | 15 minutes | 120 | 2978.00 | 2.68 | 957724.80 | |
| On-Call and Remote Support | 15 minutes | 0 | 0.00 | 1.33 | 0.00 | |
| Remote CPS Service 1:1-1:5 | 15 minutes | 0 | 0.00 | 4.94 | 0.00 | |
| Remote CPS Services 1:6 and above | 15 minutes | 0 | 0.00 | 1.91 | 0.00 | |
| **Education Support Services Total:** | | | | | | 678348.00 |
| Education Support Services | Vendor Goods and | 66 | 2284.00 | 4.50 | 678348.00 | |
| **Family Medical Support Assistance Total:** | | | | | | |
| Family Medical Support Assistance | | | | | | |
| **Homemaker/Chore Total:** | | | | | | 164924.34 |
| Homemaker/Chore | Hour | 93 | 106.00 | 16.73 | 164924.34 | |
| **In-Home and Community Support Total:** | | | | | | 105208680.62 |
| Base (1:3) | 15 minutes | 590 | 601.00 | 3.17 | 1124050.30 | |
| Level 1 (1:2) | 15 minutes | 800 | 500.00 | 4.52 | 1808000.00 | |
| Level 2 (1:1) | 15 minutes | 8556 | 1434.00 | 8.08 | 99135976.32 | |
| Level 2L (1:1 with license) | 15 minutes | 350 | 697.00 | 11.44 | 2790788.00 | |
| Level 3 (2:1) | 15 minutes | 25 | 701.00 | 15.72 | 275493.00 | |
| Level 3L (2:1 with license) | 15 minutes | 10 | 390.00 | 19.07 | 74373.00 | |
| **Respite Total:** | | | | | | 5642457.16 |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 15490 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Base - 15 min (1:4) | 15 minutes | 11 | 261.00 | 1.74 | 4995.54 | |
| Base - Day (1:4) | Day | 29 | 4.00 | 69.55 | 8067.80 | |
| Level 1 - 15 min (1:3) | 15 minutes | 37 | 228.00 | 2.32 | 19571.52 | |
| Level 1 - Day (1:3) | Day | 36 | 7.00 | 92.69 | 23357.88 | |
| Level 2 - 15 min (1:2) | 15 minutes | 38 | 171.00 | 3.47 | 22548.06 | |
| Level 2 - Day (1:2) | Day | 34 | 7.00 | 138.95 | 33070.10 | |
| Level 3 - 15 min (1:1) | 15 minutes | 1000 | 298.00 | 6.20 | 1847600.00 | |
| Level 3 - Day (1:1) | Day | 662 | 9.00 | 248.02 | 1477703.16 | |
| Level 4 - 15 min (2:1) | 15 minutes | 2 | 2.00 | 12.40 | 49.60 | |
| Level 4 - Day (2:1) | Day | 1 | 20.00 | 495.87 | 9917.40 | |
| Licensed - 1 Person - Day | Day | 6 | 11.00 | 700.00 | 46200.00 | |
| Licensed - 2 Person - Day | Day | 37 | 13.00 | 650.00 | 312650.00 | |
| Licensed - 3 Person - Day | Day | 45 | 15.00 | 450.00 | 303750.00 | |
| Licensed - 4 Person - Day | Day | 74 | 15.00 | 350.00 | 388500.00 | |
| Respite - Camp - 15 minutes | 15 minutes | 275 | 180.00 | 3.85 | 190575.00 | |
| Respite - Camp - Day | Day | 675 | 6.00 | 175.00 | 708750.00 | |
| Level 3L - 15 min (1:1 with license) | 15 minutes | 30 | 471.00 | 10.42 | 147234.60 | |
| Level 3L - Day (1:1 with license) | Day | 20 | 10.00 | 416.93 | 83386.00 | |
| Level 4L - 15 min (2:1 with license) | 15 minutes | 2 | 239.00 | 16.55 | 7910.90 | |
| Level 4L - Day (2:1 with license) | Day | 2 | 5.00 | 661.96 | 6619.60 | |
| **Supported Employment Total:** | | | | | | 11959593.75 |
| Career Assessment | 15 minutes | 147 | 263.00 | 17.75 | 686232.75 | |
| Job Finding and Development | | | | | 2062976.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 15490 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | 15 minutes | 454 | 256.00 | 17.75 | | |
| Job Coaching and Support - Base (1:2 to 1:4) | 15 minutes | 7 | 470.00 | 10.45 | 34380.50 | |
| Job Coaching and Support - Level 1 (1:1) | 15 minutes | 1534 | 337.00 | 17.75 | 9176004.50 | |
| **Supports Coordination Total:** | | | | | | 35680277.52 |
| Supports Coordination | 15 minutes | 13987 | 108.00 | 23.62 | 35680277.52 | |
| **Specialized Supplies Total:** | | | | | | 4760.00 |
| Specialized Supplies | Vendor Goods and | 17 | 56.00 | 5.00 | 4760.00 | |
| **Therapy Services Total:** | | | | | | 25930.80 |
| Physical Therapy | 15 minutes | 4 | 9.00 | 21.29 | 766.44 | |
| Occupational Therapy | 15 minutes | 4 | 1.00 | 19.71 | 78.84 | |
| Speech/Language Therapy | 15 minutes | 8 | 162.00 | 19.12 | 24779.52 | |
| Orientation, Mobility and Vision Therapy | 15 minutes | 5 | 3.37 | 18.16 | 306.00 | |
| **Supports Broker Services Total:** | | | | | | 301814.40 |
| Supports Broker Services | 15 minutes | 60 | 298.00 | 16.88 | 301814.40 | |
| **Advanced Supported Employment Total:** | | | | | | 23462.84 |
| Advanced Supported Employment | Outcome Based Unit | 4 | 1.00 | 5865.71 | 23462.84 | |
| **Assistive Technology Total:** | | | | | | 155800.00 |
| Assistive Technology | Vendor Goods and | 41 | 19.00 | 200.00 | 155800.00 | |
| **Behavioral Support Total:** | | | | | | 4063931.79 |
| Level 1 | 15 minutes | 1069 | 180.00 | 21.12 | 4063910.40 | |
| Level 2 | 15 minutes | 1 | 1.00 | 21.39 | 21.39 | |
| **Benefits Counseling Total:** | | | | | | 4332.00 |
| Benefits Counseling | 15 minutes | 10 | 38.00 | 11.40 | 4332.00 | |
| **Communication Specialist Services** | | | | | | 15.32 |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 15490 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Total:** | | | | | | |
| Communications Specialist Services | 15 minutes | 1 | 1.00 | 15.32 | **15.32** | |
| **Companion Total:** | | | | | | **25074495.52** |
| Base (1:3) | 15 minutes | 72 | 762.00 | 2.64 | **144840.96** | |
| Level 1 (1:2) | 15 minutes | 40 | 1232.80 | 3.67 | **180975.04** | |
| Level 2 (1:1) | 15 minutes | 2736 | 1429.00 | 6.33 | **24748679.52** | |
| **Consultative Nutritional Services Total:** | | | | | | **12.36** |
| Consultative Nutritional Services | 15 minutes | 1 | 1.00 | 12.36 | **12.36** | |
| **Family Medical Support Assistance Total:** | | | | | | **0.00** |
| Family Medical Support Assistance | 15 minutes | 0 | 0.00 | 18.41 | **0.00** | |
| **Family/Caregiver Training and Support Total:** | | | | | | **353.03** |
| Direct Training & Support | 15 minutes | 1 | 1.00 | 12.12 | **12.12** | |
| Training Registration & Fees | Vendor Goods and | 1 | 1.00 | 340.91 | **340.91** | |
| **Home Accessibility Adaptations Total:** | | | | | | **427828.50** |
| Home Accessibility Adaptations | Vendor Goods and | 67 | 473.00 | 13.50 | **427828.50** | |
| **Housing Transition and Tenancy Sustaining Service Total:** | | | | | | **10.94** |
| Housing Transition Services | 15 minutes | 1 | 1.00 | 10.94 | **10.94** | |
| **Music Therapy, Art Therapy and Equine Assisted Therapy Total:** | | | | | | **20042.00** |
| Music Therapy | 15 minutes | 10 | 40.00 | 15.34 | **6136.00** | |
| Art Therapy | 15 minutes | 10 | 40.00 | 15.34 | **6136.00** | |
| Equine Therapy | 15 minutes | 15 | 50.00 | 10.36 | **7770.00** | |
| **Participant-Directed** | | | | | | **3000.00** |

| | | |
|---|---|---|
| **GRAND TOTAL:** | | |
| **Total Estimated Unduplicated Participants:** | | **15490** |
| **Factor D (Divide total by number of participants):** | | |
| **Average Length of Stay on the Waiver:** | 332 | |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Goods and Services Total:** | | | | | | |
| Participant Directed Goods & Serv. | Vendor Goods and | 3 | 4.00 | 250.00 | **3000.00** | |
| **Shift Nursing Total:** | | | | | | **248220.00** |
| Shift Nursing | 15 minutes | 35 | 788.00 | 9.00 | **248220.00** | |
| **Small Group Employment Total:** | | | | | | **4840961.99** |
| Base | 15 minutes | 103 | 1823.00 | 2.29 | **429991.01** | |
| Level 1 | 15 minutes | 300 | 1777.00 | 3.52 | **1876512.00** | |
| Level 2 | 15 minutes | 285 | 1110.00 | 6.83 | **2160670.50** | |
| Level 3 | 15 minutes | 61 | 491.00 | 12.48 | **373788.48** | |
| **Transportation Total:** | | | | | | **25198314.40** |
| Public Transportation | Vendor Goods and | 4786 | 350.00 | 4.50 | **7537950.00** | |
| Transportation (Trip) | Trip | 3234 | 241.00 | 20.00 | **15587880.00** | |
| Transportation (Mile) | Mile | 1435 | 2579.00 | 0.56 | **2072484.40** | |
| **Vehicle Accessibility Adaptations Total:** | | | | | | **65000.00** |
| Vehicle Accessibility Adaptations | Vendor Goods and | 13 | 1.00 | 5000.00 | **65000.00** | |
| | | | **GRAND TOTAL:** | | | |
| | | | **Total Estimated Unduplicated Participants:** | | | **15490** |
| | | | **Factor D (Divide total by number of participants):** | | | |
| | | | **Average Length of Stay on the Waiver:** | | 332 | |

## *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 |
|---|---|---|---|---|---|---|
| **Community Participation Support Total:** | | | | | | **112581098.85** |
| Base | 15 minutes | 2940 | 2425.00 | 4.86 | **34649370.00** | |
| Level 1 | 15 minutes | 800 | 2539.00 | 4.81 | **9770072.00** | |
| Level 2 | 15 minutes | 5788 | 1767.00 | 6.34 | **64841690.64** | |
| Level 3 | 15 minutes | 263 | 773.00 | 11.79 | **2396895.21** | |
| Level 4 | 15 minutes | 5 | 140.00 | 20.53 | **14371.00** | |
| Older Adult Living | 15 minutes | 120 | 2800.00 | 2.68 | **900480.00** | |
| On-Call and Remote Support | 15 minutes | 0 | 0.00 | 1.33 | **0.00** | |
| Remote CPS Service 1:1-1:5 | 15 minutes | 12 | 100.00 | 4.94 | **5928.00** | |
| Remote CPS Services 1:6 and above | 15 minutes | 12 | 100.00 | 1.91 | **2292.00** | |
| **Education Support Services Total:** | | | | | | **678348.00** |
| Education Support Services | Vendor Goods and | 66 | 2284.00 | 4.50 | **678348.00** | |
| **Family Medical Support Assistance Total:** | | | | | | |
| Family Medical Support Assistance | | | | | | |
| **Homemaker/Chore Total:** | | | | | | **164924.34** |
| Homemaker/Chore | Hour | 93 | 106.00 | 16.73 | **164924.34** | |
| **In-Home and Community Support Total:** | | | | | | **105208680.62** |
| Base (1:3) | 15 minutes | 590 | 601.00 | 3.17 | **1124050.30** | |
| Level 1 (1:2) | 15 minutes | 800 | 500.00 | 4.52 | **1808000.00** | |
| Level 2 (1:1) | 15 minutes | 8556 | 1434.00 | 8.08 | **99135976.32** | |
| Level 2L (1:1 with license) | 15 minutes | 350 | 697.00 | 11.44 | **2790788.00** | |
| Level 3 (2:1) | 15 minutes | 25 | 701.00 | 15.72 | **275493.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **15490** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Level 3L (2:1 with license) | 15 minutes | 10 | 390.00 | 19.07 | 74373.00 | |
| **Respite Total:** | | | | | | 5590657.16 |
| Base - 15 min (1:4) | 15 minutes | 11 | 261.00 | 1.74 | 4995.54 | |
| Base - Day (1:4) | Day | 29 | 4.00 | 69.55 | 8067.80 | |
| Level 1 - 15 min (1:3) | 15 minutes | 37 | 228.00 | 2.32 | 19571.52 | |
| Level 1 - Day (1:3) | Day | 36 | 7.00 | 92.69 | 23357.88 | |
| Level 2 - 15 min (1:2) | 15 minutes | 38 | 171.00 | 3.47 | 22548.06 | |
| Level 2 - Day (1:2) | Day | 34 | 7.00 | 138.95 | 33070.10 | |
| Level 3 - 15 min (1:1) | 15 minutes | 1000 | 298.00 | 6.20 | 1847600.00 | |
| Level 3 - Day (1:1) | Day | 662 | 9.00 | 248.02 | 1477703.16 | |
| Level 4 - 15 min (2:1) | 15 minutes | 2 | 2.00 | 12.40 | 49.60 | |
| Level 4 - Day (2:1) | Day | 1 | 20.00 | 495.87 | 9917.40 | |
| Licensed - 1 Person - Day | Day | 6 | 11.00 | 700.00 | 46200.00 | |
| Licensed - 2 Person - Day | Day | 37 | 13.00 | 650.00 | 312650.00 | |
| Licensed - 3 Person - Day | Day | 45 | 15.00 | 450.00 | 303750.00 | |
| Licensed - 4 Person - Day | Day | 74 | 13.00 | 350.00 | 336700.00 | |
| Respite - Camp - 15 minutes | 15 minutes | 275 | 180.00 | 3.85 | 190575.00 | |
| Respite - Camp - Day | Day | 675 | 6.00 | 175.00 | 708750.00 | |
| Level 3L - 15 min (1:1 with license) | 15 minutes | 30 | 471.00 | 10.42 | 147234.60 | |
| Level 3L - Day (1:1 with license) | Day | 20 | 10.00 | 416.93 | 83386.00 | |
| Level 4L - 15 min (2:1 with license) | 15 minutes | 2 | 239.00 | 16.55 | 7910.90 | |
| Level 4L - Day (2:1 with license) | Day | 2 | 5.00 | 661.96 | 6619.60 | |
| **Supported Employment Total:** | | | | | | 11959593.75 |

| | | |
|---|---|---|
| **GRAND TOTAL:** | | |
| **Total Estimated Unduplicated Participants:** | | 15490 |
| **Factor D (Divide total by number of participants):** | | |
| **Average Length of Stay on the Waiver:** | 332 | |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Career Assessment | 15 minutes | 147 | 263.00 | 17.75 | 686232.75 | |
| Job Finding and Development | 15 minutes | 454 | 256.00 | 17.75 | 2062976.00 | |
| Job Coaching and Support - Base (1:2 to 1:4) | 15 minutes | 7 | 470.00 | 10.45 | 34380.50 | |
| Job Coaching and Support - Level 1 (1:1) | 15 minutes | 1534 | 337.00 | 17.75 | 9176004.50 | |
| **Supports Coordination Total:** | | | | | | 35680012.98 |
| Supports Coordination | 15 minutes | 15490 | 97.52 | 23.62 | 35680012.98 | |
| **Specialized Supplies Total:** | | | | | | 4760.00 |
| Specialized Supplies | Vendor Goods and | 17 | 56.00 | 5.00 | 4760.00 | |
| **Therapy Services Total:** | | | | | | 25930.80 |
| Physical Therapy | 15 minutes | 4 | 9.00 | 21.29 | 766.44 | |
| Occupational Therapy | 15 minutes | 4 | 1.00 | 19.71 | 78.84 | |
| Speech/Language Therapy | 15 minutes | 8 | 162.00 | 19.12 | 24779.52 | |
| Orientation, Mobility and Vision Therapy | 15 minutes | 5 | 3.37 | 18.16 | 306.00 | |
| **Supports Broker Services Total:** | | | | | | 301814.40 |
| Supports Broker Services | 15 minutes | 60 | 298.00 | 16.88 | 301814.40 | |
| **Advanced Supported Employment Total:** | | | | | | 23462.84 |
| Advanced Supported Employment | Outcome Based Unit | 4 | 1.00 | 5865.71 | 23462.84 | |
| **Assistive Technology Total:** | | | | | | 155800.00 |
| Assistive Technology | Vendor Goods and | 41 | 19.00 | 200.00 | 155800.00 | |
| **Behavioral Support Total:** | | | | | | 4063931.79 |
| Level 1 | 15 minutes | 1069 | 180.00 | 21.12 | 4063910.40 | |
| Level 2 | 15 minutes | 1 | 1.00 | 21.39 | 21.39 | |
| **Benefits Counseling Total:** | | | | | | 4332.00 |
| Benefits | | | | | 4332.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 15490 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Counseling | 15 minutes | 10 | 38.00 | 11.40 | | |
| **Communication Specialist Services Total:** | | | | | | **15.32** |
| Communications Specialist Services | 15 minutes | 1 | 1.00 | 15.32 | **15.32** | |
| **Companion Total:** | | | | | | **25074495.52** |
| Base (1:3) | 15 minutes | 72 | 762.00 | 2.64 | **144840.96** | |
| Level 1 (1:2) | 15 minutes | 40 | 1232.80 | 3.67 | **180975.04** | |
| Level 2 (1:1) | 15 minutes | 2736 | 1429.00 | 6.33 | **24748679.52** | |
| **Consultative Nutritional Services Total:** | | | | | | **12.36** |
| Consultative Nutritional Services | 15 minutes | 1 | 1.00 | 12.36 | **12.36** | |
| **Family Medical Support Assistance Total:** | | | | | | **11782.40** |
| Family Medical Support Assistance | 15 minutes | 4 | 160.00 | 18.41 | **11782.40** | |
| **Family/Caregiver Training and Support Total:** | | | | | | **353.03** |
| Direct Training & Support | 15 minutes | 1 | 1.00 | 12.12 | **12.12** | |
| Training Registration & Fees | Vendor Goods and | 1 | 1.00 | 340.91 | **340.91** | |
| **Home Accessibility Adaptations Total:** | | | | | | **427828.50** |
| Home Accessibility Adaptations | Vendor Goods and | 67 | 473.00 | 13.50 | **427828.50** | |
| **Housing Transition and Tenancy Sustaining Service Total:** | | | | | | **10.94** |
| Housing Transition Services | 15 minutes | 1 | 1.00 | 10.94 | **10.94** | |
| **Music Therapy, Art Therapy and Equine Assisted Therapy Total:** | | | | | | **20042.00** |
| Music Therapy | 15 minutes | 10 | 40.00 | 15.34 | **6136.00** | |
| Art Therapy | 15 minutes | 10 | 40.00 | 15.34 | **6136.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **15490** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Equine Therapy | 15 minutes | 15 | 50.00 | 10.36 | 7770.00 | |
| **Participant-Directed Goods and Services Total:** | | | | | | 3000.00 |
| Participant Directed Goods & Serv. | Vendor Goods and | 3 | 4.00 | 250.00 | 3000.00 | |
| **Shift Nursing Total:** | | | | | | 248220.00 |
| Shift Nursing | 15 minutes | 35 | 788.00 | 9.00 | 248220.00 | |
| **Small Group Employment Total:** | | | | | | 4840961.99 |
| Base | 15 minutes | 103 | 1823.00 | 2.29 | 429991.01 | |
| Level 1 | 15 minutes | 300 | 1777.00 | 3.52 | 1876512.00 | |
| Level 2 | 15 minutes | 285 | 1110.00 | 6.83 | 2160670.50 | |
| Level 3 | 15 minutes | 61 | 491.00 | 12.48 | 373788.48 | |
| **Transportation Total:** | | | | | | 25198314.40 |
| Public Transportation | Vendor Goods and | 4786 | 350.00 | 4.50 | 7537950.00 | |
| Transportation (Trip) | Trip | 3234 | 241.00 | 20.00 | 15587880.00 | |
| Transportation (Mile) | Mile | 1435 | 2579.00 | 0.56 | 2072484.40 | |
| **Vehicle Accessibility Adaptations Total:** | | | | | | 65000.00 |
| Vehicle Accessibility Adaptations | Vendor Goods and | 13 | 1.00 | 5000.00 | 65000.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 15490 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 332 |