

OLTL's Updated Aging Waiver Transition Plan March, 2016

Overview

OLTL's transition plan was developed with stakeholder input including public comment through multiple modes. It is OLTL's intent to comply with the new rule and implement a transition plan that assists members and their families to lead healthy, independent, and productive lives; to have the ability to live, work, and fully participate in their communities to the fullest extent possible; to fully exercise their rights as residents; and to promote the integrity and well-being of their families. The Plan outlines four phases of activity:

- 1.) Identification of tasks that need to be accomplished
- 2.) Assessment of the settings in which HCBS waiver services are provided. Settings are expected to fall within four categories:
 - a. Those presumed to be fully compliant with HCBS characteristics
 - b. Those that may be compliant, or could be compliant with changes
 - c. Those presume non-HCBS but evidence may be presented to CMS for heightened scrutiny
 - d. Those that do not comply with HCBS characteristics
- 3.) Development of remediation strategies for those settings that are not in compliance, and
- 4.) Outline a public input process that will be used throughout the phases.

OLTL will change its own processes and protocols based on the rule's requirements, will at regular intervals consistently monitor providers through a variety of mechanisms and will include stakeholder input throughout these ongoing activities. Any changes to the Transition Plan will be put out for public input and a variety of input venues will be used to ensure that participants, providers, advocates and the general public have an opportunity to express their views.

The state assures that the settings transition plan included waiver specific transition plan will be subject to any provisions or requirements included in the state's approved Statewide Transition Plan. The state will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Introduction to the Aging Waiver:

The Aging Waiver serves individuals over the age of 60 who are nursing facility clinically eligible and financially eligible for MA waiver services.

The following services are available through the Aging Waiver:

- Assistive Technology
- Adult Daily Living Services
- Community Transition Services
- Home Adaptations
- Home Delivered Meals
- Home Health Services
- Non-Medical Transportation Services
- Participant-Directed Community Supports
- Participant-Directed Goods and Services
- Personal Assistance Services
- Personal Emergency Response System (PERS)
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- TeleCare
- Therapeutic and Counseling Services

Timeline:

The HCBS transition plan for the Aging Waiver was first submitted to CMS on June 30, 2014. Prior to submission, a series of public comment opportunities were provided to stakeholders and interested parties:

- May 17, 2014 a 30-day public comment period was initiated through a Public Notice published in the Pennsylvania Bulletin
- May 23, 2014 the transition plan was distributed to various stakeholders via the OLTL ListServ and posted on the OLTL website <http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm>
- June 10, 2014 the transition plan was discussed at the Long – Term Care Subcommittee of the Medical Assistance Advisory Committee (MAAC)

- June 13, 2014 the transition plan was discussed at the OLTL HCBS Provider meeting
- June 26, 2014 the transition plan was discussed at the MAAC meeting

Based upon CMS and stakeholder feedback, OLTL made multiple revisions to the initial transition plan and began a second 30-day public comment period on November 26, 2014.

The required public notice was posted and the comment period was achieved according to the following schedule:

- October 13, 2014 discussed the transition plan at the Long – Term Care Subcommittee of the MAAC
- November 26, 2014 transition plan was distributed via the OLTL ListServ and posted on the OLTL website <http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm>
- November 29, 2014 Public Notice was published in the Pennsylvania Bulletin
- December 8 and December 10, 2014 OLTL hosted webinars for all interested stakeholders
- December 10, 2014 notification was sent out to various stakeholders, including waiver participants, through the Disability Rights Network

*The Aging waiver transition plan was submitted to CMS on December 31, 2014 and approved by CMS on March 18, 2015. What follows is an updated transition plan that includes updated results of our assessment phase, additional stakeholder activity, and more detailed remediation steps.

The Aging waiver transition plan received additional stakeholder input when it was distributed with the required public notice period for the Statewide Transition Plan in accordance with the following schedule:

- January 8, 2016 the Statewide Transition Plan containing the Aging waiver transition plan was distribute via the OLTL ListServ and posted on the OLTL website
- January 9, 2016 Public Notice was published in the Pennsylvania Bulletin
- February 9, 2016 discussed the transition plan at the Long-Term Care Subcommittee of the MAAC
- January 22 and February 1, 2016 The Department of Human Services (DHS) hosted webinars for all interested stakeholders

Participant involvement:

The Long-Term Care Subcommittee of the MAAC includes participant representation as well as advocacy representation. All members of this committee are responsible for reaching out to their constituencies to make them aware of the information that is

presented at the meetings as well as soliciting their input when asked to review and provide feedback on documents. This committee was used as a venue to seek participant and advocate input.

Additionally, Service Coordinators and direct service providers were asked to share information with Attendant Care Waiver participants.

OLTL held a Stakeholder Meeting on May 7, 2015 to discuss CMS' Final Rule related to Home and Community Based settings. There were 35 attendees representing various associations, participants, advocates, providers, and Department of Human Services' staff. Deputy Secretary Burnett provided information about the HCBS final rule. She also shared some examples of the approach of other states to the final rule. OLTL staff presented an overview of the HCBS final rule and preliminary data results of a provider self-survey that was issued in April, 2015. Stakeholder input was provided on what compliance would look like, how OLTL could become compliant, barriers to compliance and strategies for continued engagement and communication with stakeholders. Stakeholders overwhelmingly expressed that OLTL should be flexible in interpreting the rule (consumer advocates, however, disagreed). Overall, stakeholders felt that a "one size fits all" will not work, especially when evaluating providers. In addition, stakeholders believed that Person-Centered Planning should hold the most weight and be considered as the lynchpin moving forward with an approach to implement the rule. A summary report of the meeting can be found on our website at

<http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm>.

Information and updates were provided to the LTC Sub-MAAC on August 11, 2015 and October 13, 2015. Additionally, OLTL Service Coordinators and direct service providers were asked to share information with Waiver participants.

Summary of Public Input Opportunities:

OLTL's transition plan was developed with stakeholder input including public comment through multiple modes. It is OLTL's intent to comply with the new rule and implement a transition plan that assists members and their families to lead healthy, independent, and productive lives; to have the ability to live, work, and fully participate in their communities to the fullest extent possible; to fully exercise their rights as residents; and to promote the integrity and well-being of their families.

ASSESSMENT - OLTL's assessment activities included a systematic review of policy documents, provider enrollment documents and service definitions, a review of licensing requirements, and development and implementation of a provider self-survey. Data from these activities will be assessed and provider settings will be preliminarily placed into four categories: (1) Setting is fully compliant; (2) Settings that are not compliant but will be able to come into compliance through the transition planning process (3) Setting is presumed non-compliant but evidence may be presented for heightened scrutiny review; and (4) Setting does not comply. These

categories will inform the order in which OLTL will perform on-site visits, starting with settings that do not comply and ending with a sample of settings that the surveys indicate are fully compliant. These activities will give OLTL a provider perspective on settings, which will be followed by official OLTL on-site monitoring's to validate survey responses. OLTL also intended to implement a participant review tool, but due to budgetary constraints was unable to do so during the assessment phase. OLTL plans to implement the participant review tool after the approval of the state budget. These procedures and steps are outlined in the remediation section.

Assessment Results

The majority (approximately 95%) of the Aging waiver services are provided in the private homes of individuals and it is, therefore, presumed that the settings compliant with the CMS Rule.

Systemic Review of Regulations, policies, and Service Definitions: OLTL has completed a review of state laws and regulations regarding the in-home setting. OLTL collaborated with the Bureau of Human Services Licensing (BHSL) and the Department of Aging (PDA) as applicable to identify settings that are licensed by each entity to determine compliance with the HCBS rule. The results of OLTL's analysis can be found on the OLTL website here

<http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm>.

Settings Review: OLTL issued a web-based provider self-survey to all HCBS providers for OLTL waivers, and made available to all providers a paper version of the survey to complete if the provider was unable to access the web-based survey. The Electronic Provider Self-Survey tool can be found here <http://questionpro.com/t/ALHsBZSEE4>. Providers were asked to complete a survey for each site location at which they provide waiver services. OLTL received 775 completed surveys by 431 distinct providers. At the time the survey was distributed, 1100 providers were enrolled to provide services for OLTL. The 431 respondents represent a 39% response rate of all enrolled OLTL HCBS providers. OLTL conducted follow-up activities with those providers that were identified as not completing and submitting the provider self-survey. OLTL compiled and analyzed data from the Provider Self-Surveys as they potentially conform to HCBS characteristics and their ability to comply in the future. The summary results of the survey, along with a copy of the survey can be found here

<http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm>.

OLTL coordinated with the Department of Aging to validate surveys submitted by Adult Daily Living settings, which are licensed and monitored through the Department of Aging. OLTL and the Department of Aging's licensing staff reached out to those Adult Daily Living settings that did not return surveys and asked them to complete and submit a survey to OLTL.

Based on this review, OLTL preliminarily identified the settings that:

- (1) Yes, Setting is fully compliant;
- (2) Settings that are not compliant but will be able to come into compliance through the transition planning process
- (3) Not Yet. Setting is presumed non-compliant but evidence may be presented for heightened scrutiny review; and
- (4) No. Setting does not comply.

| <p><i>Category 1</i> <i>Services in settings that fully comply with the regulatory requirements because they are individually provided in the participant’s private home and allow the client full access to community living. These settings are Non-Residential service settings. Participants get to choose what service and supports they want to receive and who provides them. Participants are free to choose to seek employment and work in competitive settings, engage in community life and control their personal resources as they see fit.</i></p> | |
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| Service | Service Description |
| Assistive Technology | Assistive Technology is an item, piece of equipment or product system — whether acquired commercially, modified or customized — that ensures the health, welfare and safety of the participant and increases, maintains or improves a participant's functioning in communication, self-help, self-direction, life supports or adaptive capabilities. |
| Community Transition Services | Community Transition Services are one-time expenses for individuals that make the transition from an institution to their own home, apartment or family/friend living arrangement. The service must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure health, welfare and safety of the participant. |
| Financial Management Services | Financial Management Services (FMS) include fiscal-related services to participants’ choosing to exercise employer and/or budget authority. FMS reduce the employer-related burden for participants while making sure Medicaid and Commonwealth funds used to pay for services and supports as outlined in the participant’s individual service plan are managed and disbursed appropriately as authorized. |
| | Home Adaptations are physical adaptations to the private residence of the participant to ensure |

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| Home Adaptations | the health, welfare and safety of the participant, and enable the participant to function with greater independence in the home. |
| Home Delivered Meals | Home Delivered Meals provides meals to waiver participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. Home Delivered Meals must be specified in the service plan, as necessary, to promote independence and to ensure the health, welfare and safety of the participant. |
| Home Health Services | Home Health Services consist of the following components: Home Health Aide Services, Nursing Services, Physical Therapy, Occupational Therapy and Speech and Language Therapy. All of the above are direct services prescribed by a physician, in addition to any services furnished under the State Plan, that assist participants in the acquisition, retention or improvement of skills necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. |
| Non-Medical Transportation Services | Transportation services are services offered in order to enable individuals served on the waiver to gain access to waiver and other community activities and resources, specified by the plan of care/service plan. |
| Participant-Directed Community Supports | Participant-Directed Community Supports will be offered to participants choosing budget authority under the Services My Way model. Participant-Directed Community Supports are specified by the service plan, as necessary, to promote independence and to ensure the health, welfare and safety of the participant. The participant is the common law employer of the individual worker(s) providing services; workers are recruited, selected, hired and managed by the participant. |
| Participant-Directed Goods and Services | This service is only available through the Services My Way (budget authority) participant-directed model. Participant-Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan. These items must address an identified need in the participant's traditional service plan (including improving and maintaining the individual's opportunities for full participation in the community) |
| Personal Assistance Services | Personal Assistance Services are aimed at assisting the individual to complete tasks of daily living that would be performed independently if the individual had no disability. These services include: Care to assist with activities of daily living activities (e.g., eating, bathing, dressing, and personal hygiene), cueing to prompt the participant to perform a task and providing supervision to assist a participant who cannot be safely left alone. Health maintenance activities provided for the participant, such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the individual's service plan and permitted under applicable State |

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| | requirements. Routine support services, such as meal planning, keeping of medical appointments and other health regimens needed to support the participant. Assistance and implementation of prescribed therapies. |
| Personal Emergency Response System (PERS) | PERS is an electronic device that enables an individual at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once the “help” button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time and would otherwise need extensive routine supervision. |
| Service Coordination | Service Coordination services are services that will assist individuals who receive waiver services in gaining access to needed waiver services and other State Medicaid Plan services, as well as medical, social, educational and other services regardless of the funding source. Service Coordination is working with and at the direction of the participant whenever possible to identify, coordinate, and facilitate waiver services. |
| Specialized Medical Equipment and Supplies | Specialized Medical Equipment and Supplies are devices, controls or appliances that enable participants to increase, maintain or improve their ability to perform activities of daily living. |
| Respite | Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Federal and state financial participation through the waivers is limited to: 1) Services provided for individuals in their own home, or the home of relative, friend, or other family. Respite Services furnished in a participant’s home are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home. |
| TeleCare | TeleCare integrates social and healthcare services supported by innovative technologies to sustain and promote independence, quality of life and reduce the need for nursing home placement. By utilizing in-home technology, more options are available to assist and support individuals so that they can remain in their own homes and reduce the need for re-hospitalization. TeleCare services are specified by the service plan, as necessary to enable the participant to promote independence and to ensure the health, welfare and safety of the participant and are provided pursuant to consumer choice. |

*Category 1
Services in settings that fully comply with the regulatory requirements because the participants travel to these settings from their private homes or residences and the settings serve non-Medicaid individuals. These settings allow the client full access to community living. Participants get to choose what service and supports they want to receive and who provides them. Participants are free to choose to seek employment and work in competitive settings, engage in community life and control their personal resources as they see fit.*

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| Adult Daily Living Services | Adult Daily Living services are designed to assist participants in meeting, at a minimum, personal care, social, nutritional and therapeutic needs. Adult Daily Living services are necessary, as specified by the service plan, to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant. This service will be provided to meet the participant’s needs as determined by the assessment performed in accordance with Department requirements and as outlined in the participant’s service plan. Adult Daily Living services are generally furnished for four (4) or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a non-institutional, community-based center encompassing both health and social services needed to ensure the optimal functioning of the participant. |
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| Respite when provided in a NF *This has been deemed allowable by CMS | Services provided in a Medicaid certified Nursing Facility. Room and board costs associated with Respite Services that are provided in a facility approved (licensed or accredited) by the state that is not a private residence are reimbursable. Respite Services may also be provided in a long-term care facility on a per diem basis. |
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| Therapeutic and Counseling Services *Services may also be provided in the waiver participant’s private home. | Therapeutic and counseling services are services that assist individuals to improve functioning and independence, are not covered by the State Medicaid Plan, and are necessary to improve the individual’s inclusion in their community. |
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*Category 3
Not Yet. Setting is presumed non-compliant but evidence may be presented for heightened scrutiny review. These settings are Non-residential settings. Participants receiving Adult Daily Living services leave their private home to attend the setting as described below in the current service definition. Older Adult Day settings are licensed by the Department of Aging under 6 Pa. Code 11. However, some Older Adult Day settings are located in a Nursing Facility.*

| Type of Setting | Issue | Number of Settings | Service Setting Description |
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| Older Adult Day settings licensed by the Department of Aging under 6 Pa. Code 11 | Located on the grounds of a Nursing Facility | 4 | Adult Daily Living services are designed to assist participants in meeting, at a minimum, personal care, social, nutritional and therapeutic needs. Adult Daily Living services are necessary, as specified by the service plan, to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant. This service will be provided to meet the participant's needs as determined by the assessment performed in accordance with Department requirements and as outlined in the participant's service plan. Adult Daily Living services are generally furnished for four (4) or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a non-institutional, community-based center encompassing both health and social services needed to ensure the optimal functioning of the participant. |
| STILL UNDER ASSESSMENT | | | |
| ASSESSMENT ACTIVITIES ARE STILL OCCURRING FOR THE FOLLOWING SETTINGS. OLTL QMET TEAMS ARE CURRENTLY CONDUCTING ON-SITE VISITS TO VALIDATE SURVEY RESULTS, GATHER FURTHER INFORMATION, AND OFFER TECHNICAL ASSISTANCE TO PROVIDERS. THE RESULTS OF THE ON-SITE VISITS WILL BE ANALYZED FOR IDENTIFICATION OF ISSUES THAT NEED ADDRESSED THROUGH DEVELOPMENT OF POLICY, PROCEDURES AND SERVICE DEFINITION CHANGES. | | | |
| Type of Setting | Issue | Number of settings | Setting Description |
| DomCare | Lockable bedroom doors | 7 | A premises certified by an Area Agency on Aging for the purpose of providing a supervised living arrangement in a homelike setting. |
| Unlicensed Provider Owned and Controlled Setting | Still under assessment | Still under assessment | Provider owned housing where participants live and receive services from the provider. |

REMEDATION STRATEGIES

1. Publication of Policy, Regulations, and Waiver Amendments/Renewals

The Pennsylvania Department of Human Services' Office of Long-Term Living (OLTL) is developing a new managed long-term service and supports program for older Pennsylvanians and adults with physical disabilities called Community HealthChoices (CHC). The vision for CHC is an integrated system of physical health and long-term Medicare and Medicaid services that supports older adults and adults with physical disabilities to live safe and healthy lives with as much independence as possible, in the most integrated settings possible. The program will roll out in three phases over three years, beginning in January 2017. The first phase in period will begin on January 1, 2017 in the Southwest region of the state. The second phase in period will begin on January 1, 2018 in the Southeast region of the state, and the final phase in period will occur on January 1, 2019 for the remaining areas of the state.

As a result of the systemic assessment referenced above, OLTL discovered the need to set policy, procedures, and guidance for providers in order to more appropriately measure compliance. Therefore, in conjunction with the activities occurring with CHC and the CHC waiver application, OLTL will be working with stakeholders on the development of standards, policies, procedures and revised service definitions in order to more objectively measure characteristics of the HCBS Final Rule.

Publication of policy on Residential (Provider Owned and Controlled) settings: OLTL will work with stakeholders to develop and issue standards for residential settings in the HCBS waivers in the form of a policy.

Public Comment Target Date: March, 2016

Implementation Target Date: July, 2016

Publication of policy on Non-residential settings: OLTL will work with stakeholders to develop and issue standards for non-residential settings in the HCBS waivers in the form of a policy.

Public Comment Target Date: March, 2016

Implementation Target Date: July, 2016

Publication of policy on Individual Service Plan Documentation requirements: OLTL will issue policy on the documentation requirements for person-centered planning.

Public Comment Target Date: August, 2015
Implementation Target Date: December, 2015

Waiver Amendment/application to include Service Definition changes: OLTL will make revisions to service definitions and provider qualifications within the CHC waiver application.

Public Comment Target Date: April, 2016
Submission to CMS target Date: May, 2016

2. Provider Enrollment

OLTL's Bureau of Provider Management's Enrollment division accepts applications from providers electing to enroll to provide HCBS services. Prior to any enrollment the provider is required to complete the OLTL standard application form and materials. Effective July 1, 2015, the application form includes questions and information related to the HCBS final rule. Applicants that are identified as not in compliance with the final rule will be required to complete the provider self-survey and may be subject to an on-site visit by OLTL as well as submission to CMS for heightened scrutiny prior to enrollment, or may have additional steps to take to be compliant with the rule before their enrollment is considered complete. No applicants as of December, 2015 have been identified for needing heightened scrutiny.

In Pennsylvania's move to managed long term services and supports, services must be provided in accordance with 42 CFR §441.301(c) (4) and (5), which outlines allowable setting for home and community-based waiver services. Settings cannot be located on the grounds of a NF, Intermediate Care Facility, Institute for Mental Disease or Hospital, unless it meets the standards for the heightened scrutiny process established through the HCBS Final Rule and is included in the PCSP. The CHC-MCO must submit documentation on a quarterly basis containing a list of settings that are non-compliant.

3. Training

OLTL staff, providers, participants, family members, and Service Coordinators will receive education and training on the updated policies and procedures that are developed as a result of OLTL's assessment and remediation efforts. OLTL will periodically offer training to HCBS providers through face-to-face methods or by webinar, which will cover clarifications relating to the final rule as

well as any new policy or procedures providers will be expected to comply with. HCBS providers who need to take additional steps to come into compliance with the final rule will receive technical assistance from OLTL in order to become compliant.

Target Date: August and September, 2016

4. Monitoring and Compliance

OLTL's overall strategy will rely heavily on its existing HCBS quality assurance processes to ensure ongoing provider compliance with the HCBS final rule. This will include provider identification of remediation strategies for each identified issue, and ongoing review of status and compliance. OLTL will also provide guidance and technical assistance to providers to assist providers with ongoing compliance. Providers that do not remain compliant with the HCBS final rule may be subject to sanctions ranging from probation to disenrollment.

The Quality Management Efficiency Teams (QMETs) are OLTL's regional provider monitoring agents. The QMETs monitor providers of direct services as well as agencies having delegated functions. Each regional QMET is comprised of a Program Specialist (regional team lead), Registered Nurses, Social Workers, and Fiscal Representatives. Five teams are located throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator.

The QMET utilizes a standardized monitoring tool for each monitoring, and monitors providers against standards derived from Title 55, Chapter 52 of the Pennsylvania Code, provider requirements established in the approved waivers and any OLTL policies. OLTL will revise the QMET on-site monitoring tool to capture the new standards that will be published in July 2016. These revisions will include elements of a detailed look at every site, and review of the administered Participant Review Tool. The QMET will begin monitoring to the new standards in the beginning of 2017, which will allow providers sufficient time to complete the activities necessary to come into compliance with the new standards, policies and service definitions. Compliance with final rule requirements will be assessed and validated through a regular QMET monitoring site visit. The QMET will be conducting an onsite assessment at all sites which have been identified to be in a category that requires follow-up for compliance review. These assessments will include a walk-through of the site where HCBS services occur, as well as participant file reviews and a review of the site's policies and procedures. QMET will be responsible for monitoring providers in the regions of the State that have not yet implemented CHC. Compliance will be assessed and validated through a regular QMET monitoring site visit.

With each phase-in period of CHC, the MCOs will be responsible for ensuring providers in their networks are compliant with OLTL policies related to the HCBS Final Rule. The CHC-MCO must provide services in the least restrictive, most integrated setting. As agreed to in the CHC Agreement, the CHC-MCO must provide services in the least restrictive, most integrated setting and LTSS must be provided in accordance with 42 CFR §441.301(c) (4) and (5), which outlines allowable setting for home and community-based waiver services. This includes that CHC-MCO shall only provide LTSS in settings that comply with federal regulations; and that settings cannot be located on the grounds of a NF, Intermediate Care Facility, Institute for Mental Disease or Hospital, unless they meet the standards for the heightened scrutiny process established through the HCBS Final Rule and is included in the PCSP. The CHC-MCO must submit documentation on a quarterly basis containing a list of settings that are non-compliant.

Until CHC implementation in each region is complete, OLTL will issue a Statement of Findings (SoF) to providers listing infractions (areas of non-compliance) and immediate need for the provider to take corrective action. Based on the areas of non-compliance, OLTL will issue a Corrective Action Plan (CAP) for provider remediation. Provider remediation activities are documented in CAPs which will be requested from providers by the QMETs to correct non-compliance issues. The CAP will provide detailed information about the steps to be taken to remediate issues and the expected timelines for compliance. The provider needs to demonstrate through the CAP that it can meet the regulations and develop a process on how to continue compliance with the regulations. As part of the remediating process, areas of non-compliance with the regulations are identified from the on-site review and a SoF is generated. The provider responds to the written SoF by completing a CAP. The CAP includes some of the following: action steps to address a specific finding; explanation on how the steps will remediate the finding; date when a finding will be remediated and the agency responsible person for correcting the identified problem. The provider must implement the approved CAP. The timeframe for conducting the CAP follow-up is dependent upon the dates for completion identified by the provider. QMET determines the CAP follow-up monitoring schedule and the method (on-site vs in office) based on the action steps that were to be completed or the area which was deemed out of compliance. CAPs are to be followed-up on between 30 and 90 days of the last date listed under timeline for completion. The provider is notified of the type of follow-up to be performed 10 business days in advance of the follow-up monitoring. Regardless of the manner of follow-up, all documents reviewed should be of sufficient quantity and scope in order to determine if the action steps have been completed accurately, timely, and in accordance with the approved plan. If the follow-up is performed and all the action items are verified as complete the CAP is closed. If some items remain incomplete, QMET will provide technical assistance in order to assist the provider in remediating any outstanding items and work towards closing the CAP. No CAP

is closed until all action steps have been completed. Providers that are unable or unwilling to comply with their CAP will be disenrolled from providing HCBS waiver services for that setting and are required to adhere to **§ 52.61. Provider cessation of services.**

(a) If a provider is no longer able or willing to provide services, the provider shall perform the following:

(1) Send written notification to each participant, the Department and other providers with which the provider works that the provider is ceasing services at least 30 days prior to the provider ceasing services.

(2) Notify licensing or certifying entities as required.

(3) Send the Department a copy of the notification sent to a participant and service providers as required under paragraph (1). If the provider uses a general notification for all participants or service providers, a single copy of the notification is acceptable.

(4) Cooperate with the Department, new providers of services and participants with transition planning to ensure the participant's continuity of care.

(b) If the provider fails to notify the Department as specified in subsection (a), the provider shall forfeit payment for each day that the notice is overdue until the notice is issued.

Providers determined to be ineligible after the CAP process will be provided appeal rights.

OLTL will keep a "tracker" of HCBS providers who have been deemed out of compliance with the final rule, including how many participants they serve where they are out of compliance. OLTL will be tracking these providers and participants through the Corrective Action Plan process, and or the disenrollment process to make sure no participants, and no sites are forgotten.

OLTL waiver providers are continuously monitored for compliance during a 2-year cycle per waiver requirements.

In addition, participants will be able to report any non-compliance issues through a Participant Review Tool. OLTL has developed a Participant Review Tool to be used by service coordinators during face-to-face visits that incorporates questions designed to receive participant feedback on the settings in which they receive services. Service Coordinators will conduct a face-to-face visit with the participant and complete the department issued Participant Review Tool. This will ensure that participants have a method to provide feedback and report any non-compliance issues to OLTL through their service coordinator. The participant review tool was tested in April and March of 2015. OLTL is required to upgrade their license for the IT software that the participant review tool is housed. Due to a budget impasse, OLTL has not been able to purchase the license; therefore the participant review tool is anticipated to be implemented in June 2016.

Participants also have the ability to directly report complaints through the OLTL complaint hotline. OLTL operates a Customer Service line, also known as the OLTL HelpLine. The OLTL HelpLine (1-800-757-5042) is located in the Bureau of Participant Operations, and is staffed by OLTL personnel during normal business hours. Participants, family members and other interested parties use the HelpLine to report complaints/grievances regarding the provision/timeliness of services and provider performance. Individuals calling the OLTL HelpLine with a complaint/grievance are logged into the Enterprise Information System (EIM), a web-based database, and the information is then referred to the appropriate Bureau for resolution and follow-up.

OLTL will notify participants of all findings and compliance actions that are being taken. Individuals who will have to transfer from non-compliant or presumed non-compliant settings will get advance, accessible notice through a phone call and/or visit from their Service Coordinator in addition to a letter, which will ensure that this important information is received and understood. OLTL will work with each participant, their families, and their HCBS service providers in assisting the participant to transfer out of the non-compliant site. The participant and their families will have the option of choosing between compliant HCBS providers and non-disability specific settings.

5. Public Notice for Heightened Scrutiny:

OLTL preliminarily identified 4 settings that may be subject to heightened scrutiny due to physical location and the potential to have the effect of isolating in accordance with the HCBS Final Rule. The number of settings identified may change depending on the analysis of the QMET visits. OLTL will be working with providers during the transition period to come into compliance with the HCBS final rule by implementing OLTL specific policies and procedures for better measurement of compliance with the final rule. A public notice will be published in January 2018, which will list all settings/providers that have been found eligible for continued waiver reimbursement and meets criteria for CMS heightened scrutiny process, including the number of participants currently receiving services in those settings.

In the spring of 2018, OLTL will send a list of settings/providers identified for heightened scrutiny to CMS for their heightened scrutiny process, including the number of participants currently receiving services in those settings. Notice for the stakeholders will be published regarding the settings/providers CMS accepted as being home and community based and those that CMS denied as being home and community based.

CONTINUED OUTREACH AND ENGAGEMENT

This plan is not a onetime and done activity. Due to the many changes that OLTL will be implementing over the next several years, it is anticipated that the transition plan will need to be updated to reflect those changes as they occur. OLTL will change its own processes and protocols based on the rule's requirements, will at regular intervals monitor providers through a variety of mechanisms and will include stakeholder input throughout these ongoing activities. Any changes to the Transition Plan will be put out for public input and a variety of input venues will be used to ensure that participants, providers, advocates and the general public have an opportunity to express their views.

In addition, in order to provide OLTL with ongoing advice, a subcommittee of the Department of Human Services' Medical Assistance Advisory Committee (MAAC) has been established. The purpose of the Managed Long-Term Services and Supports (MLTSS) Subcommittee will be to review materials and advise the MAAC and the Department on policy development, program administration and new and innovative approaches to long-term services as the Commonwealth rolls out the new CHC delivery model. It will provide OLTL with advice on the design, implementation and ongoing operations, oversight and quality management of the CHC program. Membership of the committee includes consumers of long-term living services, providers of services, family caregivers and advocates. The MLTSS Subcommittee meets monthly to discuss the proposed policies and changes. OLTL will be using this forum to communicate any updates or changes to the Statewide Transition Plan (STP) as well as the OLTL waiver specific transition plan updates. Lastly, OLTL conducts stakeholder webinars every third Thursday of the month. These webinars have been primarily focused on the implementation of CHC, however, moving forward; OLTL believes this is a great opportunity to provide education and information on the STP as well as the OLTL waiver specific transition plans to our stakeholders.