1. Request Information

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*): Community HealthChoices (CHC)

C. **Type of Request:** *(the system will automatically populate new, amendment, or renewal)*

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

○	**3 years**
●	**5 years**

☐	**New to replace waiver** Replacing Waiver Number:		
	Migration Waiver – this is an existing approved waiver Provide the information about the original waiver being migrated		
	Base Waiver Number:	PA.0386	
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)	January 1, 2020	

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

○	**Model Waiver**
●	**Regular Waiver**

E. **Proposed Effective Date:** January 1, 2020

Approved Effective Date *(CMS Use):*

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 under age 21 as provided in 42 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 facility level of care:	

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:*
	The Commonwealth operates this §1915(c) waiver application concurrently with a §1915(b) waiver application to implement Community HealthChoices (CHC). The CHC 1915(b) waiver was approved by CMS for the time period of January 1, 2018 through December 31, 2022. CHC is Pennsylvania's managed long-term services and supports initiative. The 1915(b)/1915(c) concurrent waivers allow the Commonwealth to require Medicaid beneficiaries to receive nursing facility, hospice, home and community-based services (HCBS), behavioral health, and physical health services through managed care organizations (MCOs) selected by the state through a competitive procurement process.

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

✓	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
✓	§1915(b)(2) (central broker)	✓	§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 Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Commonwealth of Pennsylvania operates this §1915(c) waiver application concurrently with a §1915(b) waiver application to implement Community HealthChoices (CHC). CHC is Pennsylvania's managed Long-Term Services and Supports (LTSS) initiative. The 1915(b)/1915(c) waivers allow the Commonwealth to require Medicaid beneficiaries to receive both LTSS, including nursing facility, hospice, home and community-based services (HCBS), and physical health services through managed care organizations (MCOs). The MCOs were selected by the state through a competitive procurement process.

The CHC program serves the following:

- Individuals who are 21 years of age or older and who are financially and clinically eligible to receive Medicaid LTSS (whether in the community or in a nursing facilities).
- Individuals who are 21 years of age or older and who are fully eligible for both Medicaid and Medicare, regardless of whether they need or receive LTSS (referred to as "Dual Eligibles") excluding participants who are enrolled in the OBRA waiver or a home and community-based waiver administered by the Office of Developmental Programs.

The CHC 1915(c) waiver will serve individuals who are 21 years of age or older and who are financially and clinically eligible to receive Medicaid LTSS in the community.

CHC operates across 5 geographical zones that comprise all 67 counties. CHC will be the sole Medicaid option for full Dual Eligibles. Other nursing facility clinically-eligible consumers residing in these five zones will have the choice between CHC and the Living Independence for the Elderly (LIFE) program.

CHC serves an estimated 450,000 individuals. CHC-MCOs are accountable for most Medicaid-covered services, including preventive services, primary and acute care, LTSS (HCBS and nursing facilities), prescription drugs, and dental services. Dual Eligibles have the option to have their Medicaid and Medicare services coordinated by the same MCO.

Behavioral Health Services are excluded from CHC-MCO Covered Services. The CHC-MCO must coordinate with the HealthChoices behavioral health MCOs.

Individuals served in the CHC waiver will receive any required behavioral health services (including drug and alcohol services) from behavioral health MCOs in Pennsylvania's other 1915(b) waiver, HealthChoices. The HealthChoices waiver (designated as PA-67) was renewed for a five-year time period beginning January 1, 2017. As renewed, the HealthChoices waiver includes additional populations to accommodate individuals who participate in CHC and who need behavioral health services.

The CHC waiver is administered by the Pennsylvania Department of Human Services (DHS), Office of Long-Term Living (OLTL), an office within the Single State Medicaid Agency. OLTL contracts with the CHC-MCOs to provide services and to enforce waiver obligations. The CHC-MCOs are paid a monthly capitation rate for services. CHC-MCOs may use written contracts meeting the requirements of 42 CFR 434.6 to deliver other services. Entities or individuals under contract or subcontract with the CHC-MCO must meet provider standards described elsewhere in the waiver application.

CHC emphasizes deinstitutionalization and provides an array of services and supports in community-integrated settings.

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 state wideness that is requested *(check each that applies)*:

	Geographic Limitation. A waiver of state wideness 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. S*pecify 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 Improvement Act of 2004 (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 throughout the application and in **Appendix H**.

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

Information regarding the public input process will be added prior to submission to CMS.

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 as 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:	Hale				
First Name:	Jennifer				
Title:	Policy Director				
Agency:	Department of Human Services, Office of Long-Term Living				
Address :	6th Floor, Forum Place				
Address 2:	555 Walnut Street				
City:	Harrisburg				
State:	Pennsylvania				
Zip:	17101				
Phone:	(717) 346-0495	**Ext:**		☐	**TTY**
Fax:	(717) 265-7698				
E-mail:	jehale@pa.gov				

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

Last Name:					
First Name:					
Title:					
Agency:					
Address:					
Address 2:					
City:					
State:					
Zip :					
Phone:		**Ext:**		☐	**TTY**
Fax:					
E-mail:					

8. Authorizing Signature

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

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

Signature: _____

State Medicaid Director or Designee

Submission Date:	

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

Last Name:	Allen				
First Name:	Leesa				
Title:	Executive Deputy Secretary				
Agency:	Department of Human Services				
Address:	625 Forster Street				
Address 2:	333 Health & Welfare Building				
City:	Harrisburg				
State:	Pennsylvania				
Zip:	17120				
Phone:	(717) 787-1870	**Ext:**		☐	**TTY**
Fax:	(717) 787-2062				
E-mail:	leallen@pa.gov				

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

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

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

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

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

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

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

OLTL's Community HealthChoices (CHC) Waiver Transition Plan

Overview

OLTL's Transition Plan was developed with stakeholder input including public comment through multiple modes. The Transition Plan will assist 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 Transition 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 presumed 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. OLTL will make available any changes to the Transition Plan for public input, and OLTL will use a variety of input venues 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 with this waiver amendment 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.

The 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 18 months, beginning in January 1, 2018. The first phase in period will begin on January 1, 2018, in the Southwest region of the state. The second phase in period will begin on January 1, 2019 in the Southeast region of the state, and the final phase in period will occur on January 1, 2020 for the remaining areas of the state.

The following transition plan is a compilation of the CMS approved Aging, Attendant Care, CommCare, Independence and OBRA waiver-specific HCBS transition plans, which contain the same components and service settings, with the addition of services unique to CHC. Therefore the activities that were conducted as part of the Aging, Attendant Care, CommCare, Independence, and OBRA waivers have been included into this CHC transition plan and are reflected throughout the document.

Introduction to the CHC 1915(c) Waiver:
The CHC Waiver serves individuals over the age of 21 who are nursing facility clinically eligible and are financially eligible for MA waiver services.

The following services are available through the CHC 1915(c) Waiver:

- Adult Daily Living
- Assistive Technology
- Behavior Therapy Services
- Benefits Counseling
- Career Assessment
- Cognitive Rehabilitation Therapy Services
- Community Integration
- Community Transition Services
- Counseling Services
- Employment Skills Development
- Financial Management Services
- Home Adaptations
- Home Delivered Meals
- Home Health Aid Services
- Job Coaching
- Job Finding
- Non-Medical Transportation

- Nursing Services
- Nutritional Consultation Services
- Occupational Therapy
- Personal Assistance Services
- Personal Emergency Response System (PERS)
- Pest Eradication
- Physical Therapy
- Residential Habilitation
- Respite
- Specialized Medical Equipment and Supplies
- Speech and Language Therapy
- Structured Day Habilitation
- Telecare
- Vehicle Modifications

Timeline:
The OLTL Waiver transition plans were 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 plans and began a second 30-day public comment period.

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

- December 9, 2014 discussed at the Long-Term Care Subcommittee of the MAAC
- December 19, 2014 distributed via the OLTL ListServ and posted on the OLTL website http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm
- December 20, 014 Public Notice was published in the Pennsylvania Bulletin
- January 6 and January 8, 2015 hosted webinars for all interested stakeholders
- January 8, 2015 notification sent out to various stakeholders, including waiver participants, through the Disability Rights Network
- January 22, 2015 discussed at the Medical Assistance Advisory Committee

*The last of OLTL's transition plans were submitted to CMS on March 31, 2015. and approved by CMS on August 30, 2016. The following transition plan is a compilation of the Aging, Attendant Care, CommCare, Independence and OBRA waivers which contain the same components and service settings with the addition of services unique to CHC.

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 CommCare 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.

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

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

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 implemented the participant review tool in October 2016 to assess participant experience, which is outlined in the remediation section.

Assessment Results
The majority of the waiver services are provided in the private homes of individuals and it is, therefore, presumed that the settings are 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 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 provider 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. Furthermore, OLTL identified the residential and day settings that did not complete surveys and reached out to each of those settings. For the residential and day providers that still failed to submit a survey, OLTL's QMET team is following up with a letter and site visit to complete the survey and provide technical assistance and education on the HCBS Final Rule.

OLTL's QMET teams began on-site visits to all provider owned and operated and day settings in March 2017 and will be complete in September 2017.
Based on this review, OLTL will preliminarily identify the following:

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.

Service	Service Description
Category 1	

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. Participants get to choose what services 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.	
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.
Benefits Counseling	Benefits Counseling is a 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. This service provides an accurate, individualized assessment. The service provides information to the individual regarding the full array of available work incentives for essential benefit programs including SSI, SSDI, Medicaid, Medicare, housing subsidies, food stamps, etc.
Career Assessment	Career Assessment is an individualized employment assessment used to assist in the identification of potential career options based upon the interests and strengths of the participant. Career Assessment services are necessary, as specified in the service plan, to support the participant to live and work successfully in home and community-based settings, enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant. Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age.
Cognitive Rehabilitation Therapy Services	Cognitive Rehabilitation Therapy services are services that assist individuals to improve functioning and independence, are not covered by the Medicaid State Plan, and are necessary to improve the individual's inclusion in their community. Services are provided by an occupational therapist, licensed psychologist, licensed social worker, licensed professional counselor, or a home health agency that employs them. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

	Cognitive Rehabilitation Therapy services focus on the attainment/re-attainment of cognitive skills. The aim of therapy is the enhancement of the participant's functional competence in real-world situations. The process includes the use of compensatory strategies, and use of cognitive orthotics and prostheses. Services include consultation, ongoing counseling, and coaching/cueing.
Community Integration	Community Integration is a short-term, goal-based support service designed to assist participants in acquiring, retaining, and improving self-help, communication, socialization and adaptive skills necessary to reside in the community.
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.
Counseling Services	Counseling Services are services that assist individuals to improve functioning and independence, are not covered by the Medicaid State Plan, and are necessary to improve the individual's inclusion in their community. Services are provided by a licensed psychologist, licensed social worker, licensed professional counselor, or a home health agency that employs them. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan. Counseling services are non-medical counseling services provided to participants in order to resolve individual or social conflicts and family issues. While counseling services may include family members, the therapy must be on behalf of the participant and documented in his/her service plan.
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	Home Adaptations are physical adaptations to the private residence of the participant to ensure the health, welfare

	and safety of the participant, and enable the participant to function with greater independence in the home.
Home Health Aid Services	Home Health Aide services are direct services prescribed by a physician in addition to any services furnished under the Medicaid State Plan that are necessary, as specified by the service plan, to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The physician's order must be obtained every sixty (60) days for continuation of service. The home health aide provider is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Nursing services authorized in the service plan. Home Health Aide services are provided by a home health aide who is supervised by a registered nurse. The registered nurse supervisor must reassess the participant's situation in accordance with 55 PA Code Chapter 1249, §1249.54. Home Health Aide activities include, personal care, performing simple measurements and tests to monitor a participant's medical condition, assisting with ambulation, assisting with other medical equipment and assisting with exercises taught by a registered nurse, licensed practical nurse or licensed physical therapist
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.
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.
Nursing Services	Nursing services are direct services prescribed by a physician that are needed by the participant, as specified by the service plan, to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.
Occupational Therapy	Occupational Therapy services are direct services prescribed by a physician, in addition to any services furnished under the Medicaid 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.
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 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. Overnight Personal Assistance Services to provide intermittent
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.
Pest Eradication	Pest Eradication services are services that suppress or eradicate pest infestation that, if not treated, would prevent the participant from remaining in the community due to a risk of health and safety. Pest Eradication Services are intended to aid in maintaining an environment free of insects, rodents and other potential disease carriers to enhance safety, sanitation and cleanliness of the participant's residence. The service may be considered for inclusion in the Person-Centered Service Plan (PCSP) for a participant transitioning to the community. It can also be made available on an ongoing basis if necessary to prevent reinfestation as recommended by the Pest Control Provider and documented in the PCSP.

Physical Therapy	Physical Therapy services are direct services prescribed by a physician, in addition to any services furnished under the Medicaid 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.
Speech and Language Therapy services	Speech and Language Therapy services are direct services prescribed by a physician, in addition to any services furnished under the Medicaid 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.
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 at attorney, or reside in the home.
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 and are not covered under the Medicaid State Plan.
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.
Vehicle Modifications	Vehicle Modifications are modifications or alterations to an automobile or van that is the participant's means of transportation in order to accommodate the special needs of the participant ensure the health, welfare and safety of

	the participant and enable the participant to integrate more fully into the community.
Category 1 *Services in settings that fully comply with the regulatory requirements because the participants travel to these community service 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 services 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.*	
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.
Assisted Living Settings	Licensed setting where waiver participants may reside and receive Residential Habilitation.
Behavior Therapy Services	Behavior Therapy services are services that assist individuals to improve functioning and independence, are not covered by the Medicaid State Plan, and are necessary to improve the individual's inclusion in their community. Services are provided by professionals and/or paraprofessionals in behavior management. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan. Behavior Therapy services include the completion of a functional behavioral assessment; the development of an individualized, comprehensive behavioral support plan; and the provision of training to individuals, family members and direct service providers.
Counseling Services	Counseling services are services that assist individuals to improve functioning and independence, are not covered

**Services may also be provided in the waiver participant's private home.*	by the State Medicaid Plan, and are necessary to improve the individual's inclusion in their community.
Job Coaching (Previously Supported Employment)	Job Coaching services are individualized services providing supports to participants who need ongoing support to learn a new job and maintain a job that meets the definition of competitive integrated employment. Competitive integrated employment is full or part-time work at minimum wage or higher, with wages and benefits similar to those without disabilities performing the same work, and fully integrated with co-workers without disabilities Job Coaching can also be used to support participants who are self-employed. Job Coaching services are necessary, as specified in the service plan, to support the participant to live and work successfully in home and community-based settings, enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.
Job Finding	Job Finding is an individualized service that assists participants to obtain competitive, integrated employment. Competitive integrated employment is full or part-time work at minimum wage or higher, with wages and benefits similar to those without disabilities performing the same work, and fully integrated with co-workers without disabilities. Job Finding services are necessary, as specified in the service plan, to support the participant to live and work successfully in home and community-based settings, enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.
Nutritional Consultation Services	Nutritional Consultation services are services that assist individuals to improve functioning and independence, are not covered by the Medicaid State Plan, and are necessary to improve the individual's inclusion in their community. Services are provided by professionals and/or paraprofessionals in nutritional counseling. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.
Respite provided in a Nursing Facility *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.

Category 2
Settings that are not compliant but will be able to come into compliance through the transition planning process.

a. *DomCare Settings*
b. *Employment Skills Development settings (Previously Prevocational Service Settings)*
c. *Residential Habilitation Service settings(Provider Owned and Controlled)*
d. *Structured Day Habilitation Service settings*
e. *Unlicensed Provider Owned and Controlled Settings*

Type of Setting	Issue	Number of Settings	Service 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.
Employment Skills Development (Previously Prevocational Services)		12 Service Locations	Employment Skills Development services provide learning and work experiences, including volunteer work, where the participant can develop strengths and skills that contribute to employability in paid employment in integrated community settings. Services are aimed at furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage. Employment Skills Development services are necessary, as specified in the service plan, to support the participant to live and work successfully in home and community-based settings, enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.
Residential Habilitation	Changes are needed to ensure that all provider-owned residential settings: • Participant requests for a change in how services are delivered or a change in provider is communicated to the	43 Service Locations	Residential Habilitation services can be provided in Licensed and unlicensed settings. Licensed Settings are settings in which four or more individuals reside and are licensed as Personal Care Homes (reference 55 PA Code Chapter 2600) or Assisted Living Residences (reference 55 PA Code Chapter 2800). Unlicensed settings are provider owned, rented/leased or operated settings with no more than three residents. Residential Habilitation services are provided for up to 24 hours a day. Residential Habilitation services are designed to assist an individual in acquiring the basic skills necessary to maximize their independence in activities of daily living and to

	participant's SC. • Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. • Individuals sharing units have a choice of roommates in that setting. • Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.		fully participate in community life. Residential Habilitation services are individually tailored to meet the needs of the individual as outlined in the individual's service plan. Residential Habilitation includes supports that assist participants with acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the community. These services are individually tailored supports that can include activities in environments designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice. Supports include cueing, on-site modeling of behavior, and/or assistance in developing or maintaining maximum independent functioning in community living activities, including domestic and leisure activities. Residential Habilitation also includes community integration, personal assistance services and night-time assistance. This includes any necessary assistance in performing activities of daily living (i.e., bathing, dressing, eating, mobility, and toileting) and instrumental activities of daily living (i.e., cooking, housework, and shopping). Transportation is provided as a component of the Residential Habilitation service, and is therefore reflected in the rate for Residential Habilitation. Providers of (unlicensed and licensed) Residential Habilitation are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their Person-Centered Service Plans (PCSP) This includes transportation to and from day habilitation and employment services.
Structured Day Habilitation Services	Policy changes are needed to ensure the following are occurring: • Participants have the opportunity to choose their daily activities, are not restricted to a certain schedule,	15 Service locations	These services are directed toward the development and maintenance of community living skills. Services will normally be furnished two or more hours per day on a regularly scheduled basis, for one or more days per week. Structured day program services include supervision and specific training to allow the consumer to attain his or her maximum potential. Services may include social skills training, sensory/motor development, and reduction/elimination of maladaptive behavior. Services directed at

	and interact with others of their choosing. • Participants have access to food at any time and are given the opportunity to leave the setting to eat meals.		preparing the consumer for community reintegration (teaching concepts such as compliance, attending, task completion, problem solving, safety, money management, etc.) are also included. Physical, occupational, speech and cognitive rehabilitation therapies will also be provided in addition to the structured day program if needed as documented in the approved service plan.
Unlicensed Provider Owned and Controlled Setting		Still under assessment	Provider owned housing where participants live and receive services from the provider.

REMEDIATION STRATEGIES

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

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 Home and Community-Based Settings Requirements : OLTL will work with stakeholders to develop and issue standards for Home and Community-Based settings in the waivers in the form of a policy.
Public Comment Date: June, 2016
Implementation Date: December, 2016

Publication of policy on Individual Service Plan Documentation requirements: OLTL will issue policy on the documentation requirements for person-centered planning.
Public Comment Date: August, 2015 and revised version July 2016
Implementation Date: December, 2015 and revised version October 2016

Waiver Amendment/application to include Service Definition changes: OLTL will make revisions if necessary, to service definitions and provider qualifications within the CHC waiver application. At this time OLTL is proposing to revise the Prevocational and Supported Employment service definitions to the following: Career Assessment, Benefits Counseling, Employment Skills Development, Job Coaching, and Job Finding. OLTL believes the changes to these service definitions will help to set expectations and appropriately align incentives toward individual integrated employment and community integration.
Public Comment Target Date: April, 2016
Submission to CMS target Date: April 2017

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 March 2017 have been identified for needing heightened scrutiny.

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 CHC-MCO 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 CHC-MCOs, and 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 in the future. HCBS providers who need to take additional steps to come into compliance with the final rule will receive technical assistance from OLTL and CHC-MCOs in order to become compliant.

Dates for Training: March 2017

4. Monitoring and Compliance

OLTL will have processes in place prior to the implementation of CHC. Therefore, there will be a need for careful transitioning and coordination with the CHC-MCOs. It is important to recognize that prior to the implementation of CHC 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 were published in December, 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 indicated in the Agreement. The CHC-MCO shall only provide LTSS in settings that comply with federal regulations (January 16, 2014).

OLTL will conduct a readiness review of MCOs for compliance with the HCBS Settings Rule. This review will include the following:

1) A paper review of policies, training materials, and provider agreements that at a minimum contain the following:

- MCOs verify provider compliance with the Rule when credentialing and re-credentialing HCBS providers;
- MCO Provider Agreements contain language requiring providers to maintain compliance with the Rule; and
- Plan and process for ongoing provider education and training on the Rule.

2) An on-site visit to each MCO, during which MCOs will be required to demonstrate how the MCO would ensure ongoing compliance from HCBS providers.

3) Training for MCOs on OLTL policies and procedures implemented as a result of this transition plan.

As part of the ongoing monitoring responsibilities of the MCO, OLTL will require MCOs to review and validate 100% of provider self-assessments compared against the participant review tool conducted by the CHC-MCO service coordination, supporting documentation, and provider specific transition plans.

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, and Institute for Mental Disease or Hospital; unless it meets the standard 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 conveying the 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 with an active CAP at each phase-in period of CHC will be transitioned to the CHC-MCO for follow-up and continued monitoring. As part of the readiness review process, OLTL will work with each MCO to provide education and training on the CAP process for providers. OLTL will work with the CHC-MCO to continue that process to measure compliance with the HCBS final rule and add any recommendations and suggestions from the CHC-MCO that will enhance the process. Providers that are unable or unwilling to comply with their CAP will be dis-enrolled from providing HCBS services at that setting location 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 be tracking these providers and participants through the CHC-MCO contract monitoring process, and or the disenrollment process to make sure no participants, and no sites are forgotten.

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 CHC-MCO 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. The participant review tool was implemented in August 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 Participant HelpLine. The OLTL Participant 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 Participant HelpLine to report complaints/grievances regarding the provision/timeliness of services and provider performance. Individuals calling the OLTL Participant 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, in coordination with the CHC-MCO, 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, the CHC-MCO 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.

Prior to the implementation of CHC, OLTL will issue further guidance to CHC-MCO's on monitoring expectations vis a vis the HCBS Final Rule.

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. OLTL will be working with CHC-MCOs and 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. OLTL will continue to manage the heightened scrutiny process under CHC.

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. 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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):