



MENTAL RETARDATION BULLETIN

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF PUBLIC WELFARE

DATE OF ISSUE
August 4, 2000

EFFECTIVE DATE
November 1, 2000

NUMBER
00-00-09

SUBJECT:
**Service Preference in Medicaid Waivers
for Individuals with Mental Retardation**

BY:

Nancy R. Thaler
Deputy Secretary for Mental Retardation

SCOPE:

County Mental Health/Mental Retardation Administrators
Base Service Unit Directors

PURPOSE:

The purpose of this bulletin is to meet federal requirements that assure service preference in the provision of home and community-based services funded under a Medicaid waiver for individuals with mental retardation.

BACKGROUND:

The Department assures the Federal Health Care Financing Administration (HCFA) that individuals receiving home and community-based services under a Medicaid waiver approved under Section 1915(c) of the Social Security Act will be able to exercise certain rights relative to choice or service preference. See 42 U.S.C. § 1396n(c)(2)(c).

Office of Mental Retardation procedures applicable to this state assurance have been in place since 1985 and require revision based on clarification of federal requirements. Service preference is consistent with the values of Everyday Lives and the principles of self-determination as expressed in the Multi-Year Plan for Pennsylvania's Mental Retardation Service System.

DISCUSSION:

A. Application

This bulletin applies to the Department's Consolidated Waiver for Individuals with Mental Retardation, and the Person/Family Directed Support Waiver.

REFER COMMENTS AND QUESTIONS TO:

Appropriate Regional Mental Retardation Program Managers

This bulletin does not apply to waiver-funded services for infants, toddlers and families, which are established under MR Bulletin 00-98-07, titled: Eligibility and Freedom of Choice in Medicaid Waiver for Infants, Toddlers and Families, issued July 1, 1998. This bulletin also does not apply to individuals applying for services in an ICF/MR. Eligibility procedures and rights for ICF/MR applicants are contained in 55 Pa. Code Chapter 6210.

B. Legal Representative

Throughout this bulletin the phrase “legal representative” means a person authorized by Pennsylvania law to speak in these matters of service preference on behalf of the individual with mental retardation. Pennsylvania law permits such surrogate decision-making only where the individual with mental retardation is 18 years of age or younger. See 50 P.S. § 4402(a); 20 Pa. C.S. § 5521(f). Cf. 18 Pa. C.S. § 2713(c).

C. Identifying Individuals for Home and Services

Individuals with mental retardation can be identified by the County MH/MR Program, herein referred to as the county, through its normal intake and referral processes. Individuals can also be identified by a request to receive services or by an application for waiver-funded home and services.

D. Using an Individual Application for Services

Individuals or their legal representatives, as defined in Section B, can apply for waiver-funded home and community-based services by completion of a Home and Community Services Application, form MR-459, which is contained in Attachment 3. The county is required to make this application form available to an individual requesting services or their legal representative, and to provide assistance in completion of this form, on request.

E. Determining Eligibility

On receipt of a completed application form MR-459, the county is required to determine if the individual is likely to require an ICF/MR level of care based on criteria established in MR Bulletin 00-99-14, titled: Individual Eligibility for Medicaid Waiver Services. When the individual is determined likely to require an ICF/MR level of care, the county is required to ensure that a formal determination of the individual’s eligibility is completed within 45 days. If the applicant is applying for Medicaid on the basis of a disability (e.g., SSI), the determination of eligibility under the waiver must be completed in 90 days.

For purposes of this time period, eligibility includes both the determination of ICF/MR level of care eligibility for the waiver, and the determination of Medicaid eligibility by the County Assistance Office (CAO). For persons who already have established their Medicaid eligibility, the time period covers the period from the date of

application on the MR-459 to the date the county mails notice of its level of care determination notice to the applicant. For persons who have no Medicaid eligibility established, the time period covers the period from the date of application to the date the county mails the notice of the person's ICF/MR level of care eligibility and the CAO mails its notice of the person's Medicaid eligibility.

The determination of Medicaid eligibility should not be confused with the process the CAO undergoes in determining financial eligibility for waiver funded services. If an applicant is already Medicaid eligible, the county can notify the individual of his/her level of care eligibility in view of the person's current Medicaid eligibility status, with no CAO verification needed. If the individual does not have Medicaid established at the time of application, the county is responsible to refer the individual to the CAO for a determination of Medicaid eligibility and await the CAO's response within the current 30-day time frame. If the individual can only qualify for Medicaid under a special income category established specifically for the waiver, the county is responsible for notifying the individual based on a consultation with the CAO to verify whether a special income category can be applied. The 90-day determination period rule may be applied when the special income category is disability related.

In obtaining information for determining eligibility from the CAO, the county should not forward the CAO a copy of the eligibility determination form (Form MR-250) to generate a notice of waiver eligibility to the individual unless the individual's waiver services are expected to begin and a tentative waiver start date has been established. The CAO should only issue a notice of eligibility for waiver services based on receipt of a completed Form MR-250 by the county, not as a result of its Medicaid eligibility consultation with the County MH/MR Program.

Individuals who are determined by the county to be likely to require the ICF/MR level of care have the right to be informed by the county of feasible services under the waiver. In assessing whether an individual is likely to require an ICF/MR level of care, the county or its designee is responsible for reviewing existing psychological, medical and social information about the individual. This review is in accordance with the county's requirement under 55 Pa. Code Chapter 6201 to diagnose, appraise and evaluate mental retardation and associated disabilities; define strengths, skills and attributes of the individual, and assess the needs of the individual and his/her family.

If the county or a designee determines that an individual is not likely to require an ICF/MR level of care, the county is required to notify the individual or legal representative of this determination and offer an opportunity to have a formal review conducted by a qualified mental retardation professional. There is no right to fair hearing based on the county's initial review. If a formal review is requested, the county is required to ensure that the review and a county determination on level of care and financial eligibility are completed within 45 days from the date of request for the formal review. In instances where level of care eligibility includes a determination of Medicaid eligibility based on a disability, the county's determination on level of care eligibility needs to be completed within 90 days from the date of the initial request.

F. Denial of an Application

The county is required to deny an application for waiver-funded services when any one of the following conditions apply:

1. the individual has been determined to not meet the ICF/MR level of care criteria as established by the Department;
2. the individual or legal representative, as defined in Section B, opposes home and community-based services;
3. a cost-effective individual program plan cannot be developed to meet the individual's needs for home and community-based services. For further information on cost-effectiveness, see Section P;
4. the individual does not meet Medicaid eligibility requirements pursuant to his/her current Medicaid eligibility notice from the CAO.

When an application for waiver-funded services is denied, the county is required to review other services the individual is eligible to receive.

The county is required to notify the individual or legal representative in writing when the county denies an application for home and community services funded under the waiver. The county's notification should include a full statement of the nature of the action, the reason for the action, the specific regulations or rules that support the action, and information regarding the individual's right to a fair hearing. A copy of the current MA eligibility notice from the CAO satisfies this requirement for a statement for individuals denied service due to Medicaid eligibility. Further information regarding fair hearings is contained in Section M and Attachment 2.

G. Informing Individuals About Waiver-Funded Services

The county is required to assure that all individuals requesting services who are likely to require an ICF/MR level of care, or their legal representatives, as defined in Section B, are informed of feasible home and community-based services funded under the waiver. This requirement must be met before an individual is given the choice, herein referred to as service preference, to receive Medicaid funded services in an ICF/MR or in their home and community under the waiver.

Feasible home and community-based services, for purposes of this bulletin, mean sufficient and appropriate home and community-based services and support that an individual needs or is likely to need in the home and community. Feasible services include services and supports that can be developed in the future, even if they are not currently available to meet the individual's needs due to funding, Department allocation,

or provider capacity. Additional information on explaining feasible alternatives is contained in Section I of this bulletin.

H. Determining Priority for Medicaid Waiver Funding

To the extent that feasibility of waiver enrollment is contingent upon available funding, the county is required to inform the individual or legal representative, as defined in Section B, about the category in which the individual's needs have been assessed through the PUNS (Priority of Urgency of Need for Services) assessment process and about the county's process for requesting funding from the Department. Waiver enrollment is to be offered to applicants based on the PUNS established by the County MH/MR Program. Applicants assessed as having an "emergency need" must receive preference in waiver funding before those assessed in critical needs or planning needs, as defined in PUNS.

The individual/legal representative has the right to a Department fair hearing on the basis that a claim for services is not acted upon with reasonable promptness, without any delay due to administrative procedures. Reasonable service promptness determinations are a responsibility of the county based on the conditions and urgency of need presented by the individual/family. When waiver funding for services is not expected to be available within 90 days from the date of determination, the county is responsible to notify the individual that services will be delayed and to ensure that the individual is included in the county's PUNS. The county is expected to ensure that the PUNS for the individual is completed and the individual/family is notified of the individual's service priority on PUNS within 90 days of the initial notification of the delay in services.

The individual or legal representative has the right to mediation or fair hearing and appeal if the individual's claim for services is not acted upon with reasonable promptness. This includes instances when services are delayed due to administrative procedures, Department allocation, and when the individual is assigned to PUNS. The county should be prepared to provide information on its PUNS process and procedures as part of a fair hearing that draws the PUNS into question.

I. Explaining Home and Community-Based Service Alternatives

The county is required to ensure that the individual or legal representative, as defined in Section B, is informed of feasible service alternatives within the county's jurisdiction and within reasonable commuting distance of the applicant's residence, including services in neighboring counties. The county where the individual resides or is planning to reside is required to provide information about both home and community-based services and ICF/MR services, and to assist the individual or his/her legal representative in contacting home and community-based service providers, other counties and ICFs/MR on request. Counties which receive requests for information about services for people residing in another county are required to provide the requested information along with other assistance that may be necessary.

The county can designate part or all of its responsibilities to provide information about feasible service alternatives to a service/case manager or other qualified mental retardation professional or agency, as long as this designee does not present a conflict of interest in presenting this information to the individual. Conflict of interest, for purposes of this bulletin, is defined in accordance with the Fiscal Manual for the County MH/MR Program, 55 Pa. Code 4300.140.

J. Explaining Service Preference of Waiver-Funded Services and ICF/MR

Whenever an individual is determined by the county to require an ICF/MR level of care, the county is required to offer the individual or legal representative, as defined in Section B, the opportunity to designate a preference to receive home and community services funded under the waiver or to receive care in an ICF/MR.

When explaining service preference between waiver-funded services and ICF/MR, the county is required to explain that the individual's receipt of waiver services is contingent upon:

1. confirmation that the individual qualifies for Medical Assistance;
2. the county's allocation of sufficient waiver funding and recipients to support waiver enrollment for the individual;
3. the development of a cost-effective individual program plan for home and community-based services for the individual;
4. whether qualified home and community-based service providers are available to address the individual's needs; and
5. the county's PUNS process for establishing home and community-based funding and service priorities.

The county is required to explain that waiver and ICF/MR service preference does not limit the individual to receipt of services in a particular county. The county can contract for waiver funded services directly with providers serving the individual in the receiving county, make waiver funding available through an administrative arrangement with the receiving county, or arrange a transfer of funding to the receiving county with the assistance of the Regional Office of Mental Retardation. Funding for waiver services is based on the individual's program plan developed with the receiving county and/or with providers in the receiving county. Similarly, the county is required to assist the individual in locating ICF/MR services located in other counties.

For purposes of this bulletin, the individual program plan means the document that is authorized by the County MH/MR Program to satisfy the Department's assurance that an individual "plan of care" will be in place for all recipients of waiver-funded

services. This plan is referred to as the person/family directed support plan for individuals enrolled in the Person/Family Directed Support Waiver.

The requirements of the individual program plan are established pursuant to the Department's grant agreement with the county and the approved waiver application for the services being provided. Additional information on cost effectiveness determinations in the individual planning process is contained in Section P.

The county is required to explain that state-operated ICFs/MR are not a service option for children pursuant to MR Bulletin SC-94-01, titled: Closure of Admissions of Children to State-Operated Intermediate Care Facilities for the Mentally Retarded, issued: 12/14/94. Specific state-operated ICFs/MR may also be precluded when admission or continued stay in an ICF/MR is countermanded by a settlement decree, court order, or Department policy. Regional Offices of Mental Retardation are available to provide assistance to counties and individuals in locating ICFs/MR outside of the county's area.

If an individual is eligible for more than one home and community-based waiver, the county is required to inform the individual or legal representative about the feasibility of each option and to explain that:

1. the individual can receive services under only one waiver at a time;
2. the individual or his/her legal representative has the right to change their service preference at any time by contacting their service manager and completing a new service preference form; and
3. funding for services under a different waiver will be based on the needs identified in the individual's program plan and the Department's allocation of funds and waiver recipients to the county.

K. Offering Service Preference

The county is required to use the Home and Community-Based Services Preference Form, form MR-457, in offering an individual or legal representative, as defined in Section B, service preference between waiver-funded services and ICF/MR. A copy of the form is contained in Attachment 1. Additional copies of the form, including a Spanish version, may be obtained by contacting the Regional Office of Mental Retardation.

A preference for waiver-funded services must be expressed prior to the county's authorization of waiver funding. Federal financial participation for services cannot precede the date the individual or legal representative signs the service preference form.

The opportunity to designate a service preference should not be offered prior to completion of a formal assessment of need for ICF/MR level of care in accordance with Department requirements which are currently in MR Bulletin 00-99-14.

Service preference can be offered by a case/service manager or other designee of the county who does not have a conflict of interest, as defined under 55 Pa. Code Chapter 4300.140. A provider of waiver or ICF/MR services, except for a case management agency designated by the county, should not be delegated this responsibility.

The individual or legal representative can change their service preference between waiver-funded services and ICF/MR at any time by completion of a new service preference form. An individual or legal representative who wants to apply for services under another waiver for individuals with mental retardation can do so at any time without completing a new service preference form. The decision to apply for or seek services under another waiver should be documented in the individual's record.

If an individual or legal representative refuses to designate service preference on the service preference form provided by the Department, form MR-457, the county is required to document that the preference has been offered and that the individual or his/her legal representative has refused to designate a preference for services. Refusing to designate a service preference does not alter the county's requirement to assist the individual in locating needed services, or prevent the individual from declaring a service preference at another time, even when these services are not funded under the waiver. Waiver funding can be authorized for individuals who refuse to make preference for home and community-based services, as long as the individual does not oppose home and community based services, as explained in Section L.

If an individual or legal representative indicates ICF/MR as his/her service preference, the county is required to refer the individual to ICFs/MR which may be appropriate to the individual's needs.

L. Individual and Legal Representative Participation

The county is required to ensure that the individual or that individual's legal representative, as defined in Section B, has the opportunity to designate a service preference between waiver-funded home and community-based services and ICF/MR. Designation of service preference is made by signifying a preference on the Home and Community-Based Services Preference form, MR-457.

For individuals age 18 and younger, a legal representative is responsible for designating the individual's service preference between waiver-funded home and community-based services and ICF/MR. The legal representative is the individual's parent(s) or legal guardian.

Children and youth in foster family care would have the service preference form, MR-457, signed by the child's parent or custodial County Office of Children, Youth and

Families. The decision on which party signs the form should be coordinated by the County Office of Children, Youth and Families on request of the responsible County MH/MR Program.

For individuals age 19 and over, the individual eligible for an ICF/MR level of care designates service preference. If an individual cannot signify a preference between waiver-funded home and community-based services and ICF/MR by initialing or making a mark on the service preference form, the individual's preference shall be designated with the assistance of an independent qualified mental retardation professional (QMRP) assigned by the county.

The QMRP must be independent to the extent the QMRP is not a relative of the individual, an employee of the County MH/MR Program, or an ICF/MR or waiver-funded services provider or employee. The QMRP shall designate the individual's service preference by signing both the person's and the QMRP's name on page 2 of the form, and by initialing service preference on behalf of the individual on page 1 of the form.

The role of the QMRP is limited to the following activities:

1. documenting verbal or other expression or communication by the individual that directs the qualified mental retardation professional to designate the individual's preference for either home and community-based services or care in an ICF/MR;
2. documenting observation of the individual's verbal and non-verbal expressions, and/or physical and behavioral responses in home and community-based service settings.

If the individual makes a verbal or non-verbal expression, response or communication that directs the independent QMRP to designate preference for care in an ICF/MR, the QMRP is authorized to interpret this expression as the individual's service preference for care in an ICF/MR and to sign the individual's preference for ICF/MR.

If the individual makes a verbal or non-verbal expression, response or communication that directs the independent QMRP to designate the person's preference for home and community services, the QMRP is authorized to interpret this expression as the individual's service preference for home and community services.

For individuals who make no response directing the QMRP to designate the person's choice for either ICF/MR or home and community services, the QMRP must designate the person's preference for home and community services when the individual does not oppose receiving home and community services that would be provided for the person outside of an ICF/MR. If the individual demonstrates through actions, expressions and other communication that he/she opposes home and community services, the QMRP is authorized to select ICF/MR care as the individual's service preference. See *Olmstead v L.C.*, 119 S. Ct. 2176, 2181 (1999).

M. Fair Hearing and Appeal

An individual or legal representative, as defined in Section B, has the right to a fair hearing before the Department of Public Welfare (DPW), Bureau of Hearings and Appeals, for any one of the following adverse actions:

1. the individual is determined by a qualified mental retardation professional, based on the referral from the County MH/MR Program, to not have mental retardation or require an ICF/MR level of care as a result of the level of care determination process, which is currently established under MR Bulletin 00-99-14, titled: Individual Eligibility for Medicaid Waiver Services;
2. the individual or legal representative is not given the opportunity to express a service preference for either waiver-funded services or ICF/MR;
3. the individual or legal representative is denied their service preference of waiver-funded services or ICF/MR;
4. the individual or legal representative is denied waiver-funded service(s) of their choice on the individual's program plan, including the amount, duration and scope of services;
5. the individual or legal representative is denied a qualified waiver service provider of their choice on the individual's program plan or their choice of an ICF/MR provider; and
6. the individual or legal representative is dissatisfied with a decision or action taken to refuse, suspend, reduce or terminate a waiver-funded service after the county has authorized the service.

The county is required to explain the right to fair hearing to individuals and their representatives and to provide the individual/ representative with a copy of Department fair hearing and appeal procedures when any of the following actions occur:

1. the individual is determined likely to require an ICF/MR level of care and is given information about waiver-funded services;
2. the individual or legal representative is asked to sign the service preference form;
3. there is a decision or action taken to deny the individual a waiver-funded service or provider of his/her choice;
4. there is a decision or action taken to refuse, suspend, reduce or terminate waiver-funded home and community services authorized under the individual

program plan. A delay of services based on availability of waiver funds or on a waiting list situation can be appealed on this basis;

5. the individual or legal representative notifies the county of their decision to file an appeal, or requests information about the individual's appeal and fair hearing rights under the waiver;
6. whenever there is an action taken affecting the individual's claim for eligibility or receipt of services.

Agreeing to services in the individual program plan does not prevent the individual from filing for a fair hearing regarding these services. Whenever the individual/legal representative is asked to sign approval of the individual program plan and changes to that plan, the county should notify the individual of his/her right to appeal, but does not need to provide a copy of fair hearing procedures unless an adverse action is included as part of the plan. A statement in the plan documenting that the individual is informed of his/her rights to mediation/fair hearing can be established for this purpose.

Certain waiver actions related to level of care and Medical Assistance eligibility are also subject to fair hearing and appeal procedures established through the CAO, and the county is required to participate in these hearings as appropriate. County participation is expected whenever the CAO action is based on a level of care determination. The county will receive notice of the hearing from the Department.

Fair hearings and appeals do not apply to changes caused solely by federal or state law, regulations and policy requiring a change in the type of services available under the waiver. Also excluded from the fair hearing process are changes solely established by a waiver amendment approved by HCFA, a non-Medicaid service funded outside of the waiver, and service provided during a period in which the individual is ineligible for waiver funding. The Department's fair hearing rights apply to all Medicaid services.

Choice in the method of provider reimbursement, such as individual accounts, can be offered to individuals receiving waiver services. The county's decision on a provider's payment methodology is an administrative decision that is not subject to fair hearing and appeal before the Department's Bureau of Hearing and Appeals.

The county is required to provide an individual or legal representative with an advance notice of at least 10 days when it decides to take an action that would be subject to appeal. If the individual files an appeal before the date the action is to become effective, the county is required to continue the service without taking the action until the appeal is resolved. If the county does not provide the advance notice, the individual has a right to maintain services at their current level if the appeal is made within 10 days of the individual being informed of the action. Services which are denied without first being authorized on the individual program plan cannot be continued and therefore do not need to be provided and are not subject to the 10-day allowance. While the 10-day allowance does not apply in these situations, the individual may appeal the denial.

All actions must be appealed within 30 days of notification of the action by the county to be considered by the Department, except when the individual or legal representative agrees to meet with the county in an attempt to resolve the matter outside the DPW appeal and fair hearing process. In these situations, the Department will consider the appeal to be filed in a timely fashion when the appeal is made within 30 days of the county's notice of a decision on the action based on the meeting with the individual or representative. If the appeal is filed within 10 days of notification of the results of the county meeting, services must continue without being changed as long as the appeal is related to services that are currently being provided. The county, with the approval of the individual or legal representative, may invite a disinterested third party, such as a parent training or community resource center, to participate in the county meeting. The purpose of the disinterested third party would be to encourage the use and explain the benefits of an independent mediation process as a means of resolving disputes, as further explained in Section N.

Appeals must be filed in writing to the Bureau of Hearing and Appeals using form MR-458, with a copy to the county and Regional Office of Mental Retardation. Attachment 2 contains instructions and the request form to be used for this purpose.

N. Mediation

The county is responsible for ensuring that procedures are in place to afford a party who presents a complaint with respect to the identification, evaluation, or the provision of appropriate services, the opportunity to resolve disputes through an independent mediation process. The purpose of mediation is to facilitate through a conflict resolution process, the prompt, amicable resolution of service related disagreements and conflicts involving individuals and families, counties and other parties.

Discussions that occur during the mediation process shall be confidential and may not be used as evidence in any subsequent due process hearings or civil proceedings and the parties to the mediation process may be required to sign a confidentiality pledge prior to the commencement of this process.

The county is responsible for informing the individual or legal representative, as defined in Section B, of this bulletin, regarding their right to mediation through an independent mediation entity, which is currently the Office for Dispute Resolution (ODR). An ODR mediator is available on request of and at no charge to the County MH/MR Program or an individual receiving services or the individual's legal representative. The address and phone numbers for ODR is:

Office for Dispute Resolution
6340 Flank Drive, Suite 600
Harrisburg, Pennsylvania 17112
In Pennsylvania telephone: (800) 992-4334.
Out of State telephone: 717-541-4960

A provider of services does not have a right to issue a request for mediation although a provider may be invited to participate in the mediation process by the independent mediator. The legal counsel of a party in the dispute is also excluded from issuing a mediation request. Legal counsel for any party of the dispute is not permitted to participate in any mediation meeting.

Mediation shall be available whenever a hearing is requested in accordance with Department Fair Hearing and Appeals, as described in Section M of this bulletin. County procedures shall ensure that the mediation process is:

1. voluntary on the part of the individual, family or legal representative;
2. not used to deny or delay the individual's or legal representative's right to a due process hearing under 42 CFR Part 431, Subpart E or to deny other rights which are afforded the individual under law;
3. conducted by a qualified and impartial mediator who is trained in effective mediation techniques.

The county is responsible for ensuring that the individual or legal representative is notified of mediation procedures whenever the individual or legal representative is notified of the right to Department fair hearing and appeal, in accordance with Section M of this bulletin.

A request for mediation may be made orally or in writing to the County MH/MR Program or its designee, or directly to the independent mediator designated by the Department, which is currently ODR. If the request for mediation comes to the county directly, the county shall immediately notify the Department's designated mediator, with a copy to the party making the request.

The independent mediator is responsible to ensure that the mediation process is scheduled within 10 days of notification, held in a location that is convenient to the parties to the dispute, completed in a timely fashion, and documented in a written mediation agreement reached during the conflict resolution process, that includes time frames for implementation of changes, and outstanding issues. The county is responsible to participate in the mediation process and to cooperate with the independent mediator in all aspects of the conflict resolution. The county is responsible for monitoring to ensure that actions/changes are carried out in accordance with the conditions and time frame set forth in the mediation agreement.

Copies of mediation agreement and status reports shall be retained by the county for three years and be available to representatives of the Department of Public Welfare and the Department of Health and Human Services on request.

If a request for mediation is filed within 10 days of the individual or legal representative being informed of an action or in concert with the filing of a Department appeal for fair hearing made within 10 days of the action, the county is responsible to

continue services until the Department hearing officer issues a decision, unless the request for fair hearing is withdrawn by the individual or legal representative based on the results of the mediation.

O. Provider Choice and Access in Medicaid Waiver

In accordance with Medical Assistance requirements, the individual's right to provider of choice applies to any provider who:

1. is qualified to render services in accordance with the standards and criteria established in the Department's approved waiver applications;
2. signs a provider agreement for the provision of waiver-funded services in accordance with Department procedures which are currently contained in MR Bulletin 6000-90-04, titled: Provider Agreements Under the Waiver; and
3. agrees to offer cost effective services in accordance with the Fiscal Manual for the County MH/MR Program, 55 Pa. Code Chapter 4300.

A provider can refuse to offer services for due cause, which may include conflict of interest, conflict with the provider's service admission policy, and a determination by the provider that the service needs of the person are beyond the provider's ability to address in accordance with state and federal requirements.

In arranging for waiver-funded services, the county cannot limit access to qualified providers in any way that would violate the Department's assurance of freedom of choice under this waiver. Qualified providers of service who meet provider qualifications in the Department's approved waiver application cannot be denied access to providing services on the basis of single source contracting or other practices which would deny or limit choice of qualified providers by the individual or his/her legal representative.

Although a denial of a qualified provider is subject to fair hearing and appeal, the county is authorized to deny the choice of a qualified provider when:

1. the provider does not sign or comply with a service contract or agreement required in accordance with the County MH/MR Fiscal Manual, Pa. Code Chapter 4300 and provisions of the county's grant agreement with the Department;
2. the provider's rate or schedule of charges for service is higher than necessary and reasonable for the service, as determined by the County MH/MR Program;
3. the provider has failed to deliver services in accordance with the individual's program plan.

The choice of provider under waiver-funded service management extends to the choice of an eligible provider of Medicaid funded service management. For services funded under targeted service management (TSM), provider choice extends to any provider of services designated by a County MH/MR Program to provide service management in accordance with conflict free and other conditions set forth in the county's TSM agreement with the Department. This choice extends to any service management provider agency in or outside the area where the individual resides, including any service management provider located in another county. For individuals receiving waiver-funded service management, the choice of provider extends to any provider who meets the qualifications for providing this service in accordance with Department's approved waiver application. This choice includes service management providers in and outside of the County MH/MR Program where the individual resides. Individuals also have the right to request a service manager for either TSM and waiver funded service management. The provider is responsible for considering this request in its assignment of a qualified service manager for the individual/family. The county is required to ensure that individuals receiving services and their legal representative are informed of this choice.

A county must consult with the Department before restricting access through suspension or other method to providers who have abused the Medicaid or waiver program. This process must be approved by the Regional Office of Mental Retardation in accordance with 42 CFR 431.54. The process must ensure that:

1. There are findings to document that in a significant number or proportion of situations, the provider has furnished:
 - a. waiver services at a frequency or amount that does not comply with the individual's plan; or
 - b. waiver services that do not meet professionally recognized standards of care and quality.
2. The provider is given notice and opportunity for a hearing.
3. HCFA and the public are notified of the decision to place restrictions on the provider and the duration of the restriction.
4. The restrictions do not result in denying recipients reasonable access to services of adequate quality.

P. Cost Effectiveness in Medicaid Waiver Services

In determining whether a cost-effective individual program plan can be developed for waiver-funded services, the county is required to consider cost-effectiveness standards established in both the approved waiver application and in the Fiscal Manual for the County MH/MR Program, 55 Pa. Code Chapter 4300.

Cost-effectiveness under the Consolidated Waiver allows the county to exclude an individual from the waiver when there is reasonable expectation that home and services would be more expensive than the Medicaid services the individual would otherwise receive in an ICF/MR. This option can be exercised by the County MH/MR Program based on its availability of state and federal funds allocated by the Department. The exclusion does not prohibit the county from serving individuals under the waiver whose cost of home and community services is more than the cost of ICF/MR care as long as the average cost of all waiver recipients is maintained within the state's cost-effectiveness limits as established in the county's allocation.

Cost-effectiveness under the P/FDS Waiver requires that waiver funding does not exceed the annual fiscal year limit established in the Department's approved waiver application, which is currently \$20,000.

In accordance with the Department's Fiscal Manual for the County MH/MR Program, the county is required to determine necessary and reasonable fees for the purchase of services. The availability of alternative methods for purchasing services may not be construed as mandating the payment of a fee which is higher than necessary and reasonable for the service. A fee that is necessary and reasonable means a fee that is not extreme or excessive based on the individual's needs. A necessary and reasonable fee does not mean the lowest bid for a service.

In accordance with state assurances to HCFA, the county is required to ensure that average per-capita costs for waiver-funded services comply with conditions established in the Department's grant agreement covering the administration of waiver services by the county. For the Consolidated Waiver for Individuals with Mental Retardation, these conditions are currently established pursuant to MR Bulletin 00-96-08, titled: 2176 Waiver Supplemental Grant Agreement for 1996-2000, issued July 12, 1996. For the Person/Family Directed Support Waiver, these conditions are established in MR Bulletin 00-00-03 titled: Person/Family Directed Support Waiver Supplemental Grant Agreement for 1999-2002.

A denial of services based on cost effectiveness of an individual's program plan is subject to fair hearing and appeal in accordance with instructions and further information provided in Section M and Attachment 2.

Q. County Planning and Budgeting

The county is required to ensure that all individuals who have selected a preference for home and community-based services under the waiver are considered in the county's planning and budget process including the county's PUNS with the Department, whenever an individual has:

1. been determined to have mental retardation and to be eligible for an ICF/MR level of care;

2. selected a preference for home and community-based services under the waiver; and
3. an unmet need for home and community-based services to assure the individual's health and welfare.

The county is required to maintain documentation at a centralized location which identifies:

1. the name or unique identifier of these individuals until needed services are provided; and
2. when funding for the individual's home and community services has been requested from the Department in accordance with the Department's Annual County Plan and Budget Request Guidelines and the county's PUNS.

Information related to this documentation is to be made available to the individual or legal representative on request.

R. Process Summary for Medicaid Waivers

The following process summary describes implementation of the state's assurance relating to service preference in combination with other waiver requirements. Variations for individuals coming from ICFs/MR and nursing facilities are indicated in parentheses. Counties are encouraged to complete some steps simultaneously. Persons with other related conditions to mental retardation should be referred to the Office of Social Programs for enrollment into an ICF/ORC or to one of its Medicaid waivers serving persons with other related conditions.

Steps 1-4 are expected to be completed within a period of 45 calendar days, except when the steps include a determination of eligibility based on disability, such as SSI eligibility determination, in which case the period is within 90 calendar days.

Step 1. Individual applies to the County MH/MR Program for home and community-based services or is recommended or identified by the county for waiver-funded home and community services.

Step 2. Psychological, social, and medical information about the individual is reviewed by the county designee to determine if the individual is likely to qualify for an ICF/MR level of care in accordance with MR Bulletin 00-99-14, titled: Individual Eligibility for Medicaid Waiver Services. (Utilization review or other recertification of need can be substituted for individuals coming from ICFs/MR and nursing facilities.)

2a. If it is determined that the individual is not likely to qualify for an ICF/MR level of care, the county informs the individual or legal representative with notice that this determination is subject to further assessment by an independent qualified mental

retardation professional on request. The waiver enrollment process ceases unless the individual or representative disagrees with the determination. If this occurs, proceed to Step 4. If the individual is not likely to qualify for waiver funding, the county should proceed with identifying other resources based on the individual's needs.

2b. If it is determined that the individual has mental retardation and is likely to qualify for an ICF/MR level of care, proceed to Step 3.

Step 3. The county explains feasible home and community-based services to the individual and/or legal representative.

3a. If the individual or legal representative chooses to access waiver-funded services or care in an ICF/MR, proceed to Step 4.

3b. If the individual or legal representative chooses not to access waiver-funded services or care in an ICF/MR, refer and assist the individual in accessing other resources, as needed.

Step 4. The individual is referred for a formal assessment of need for the ICF/MR level of care and an assessment is completed by a qualified mental retardation professional (QMRP) in accordance with MR Bulletin 00-99-14, titled: Individual Eligibility for Medicaid Waiver Services. The county determines the need for ICF/MR level of care.

4a. If the individual is determined to qualify for ICF/MR level of care, notify the individual of the ICF/MR level of care determination and of the individual's Medicaid eligibility status. If waiver funding is not available, notify individual of delay and complete PUNS in 90 days from date of notification, and explore other funding sources. Proceed to Step 5 but do not complete MR-250 until a tentative waiver start date is established.

4b. If the individual is determined to qualify for ICF/MR level of care and service funds are available so that a tentative waiver start date can be established, the county completes form, MR-250 and forwards this to the CAO. Then proceed to Step 5.

4c. If the individual is determined not to qualify for ICF/MR level of care, the waiver enrollment process ceases, unless there is a change as a result of mediation, fair hearing and appeal. Inform the individual/legal representative of this determination along with the right to mediation, fair hearing and appeal.

Step 5. The individual or legal representative designates service preference between waiver-funded services or care in an ICF/MR.

5a. If the individual or legal representative makes the preference for waiver-funded home and services, proceed to Step 6. Service funding cannot be authorized under the waiver prior to the date on the MR-457.

5b. If the individual or legal representative makes the preference of ICF/MR, assist the individual or legal representative in identifying ICFs/MR that may meet the individual's needs.

5c. If the individual or legal representative chooses not to designate a service preference, the county documents that service preference was offered and refused. The county should assist in identifying other resources, as appropriate, and must notify the Department if refusal to signify a service preference jeopardizes the individual's health and safety. Waiver services can be authorized for individuals who refuse to designate a service preference in accordance with Section K.

Step 6. The county forwards the completed form MR-250 to the CAO based on an expected waiver services start date, allowing 30 days for the CAO to issue a 162 series notice that establishes whether the individual is eligible for waiver services. The notice goes to the individual or legal representative and the County MH/MR Program or its designee. Eligibility can also be confirmed verbally by the county and followed-up in writing by the CAO notice.

6a. If the individual is denied eligibility and appeals the determination, the county withholds authorization of waiver services until the appeal is resolved. If there is no appeal, the process for waiver enrollment ceases. CAO fair hearing and appeal procedures apply here, although the County may be included in the appeal when the 162 notice is based on a county decision on level of care.

6b. If the CAO establishes that the individual is eligible to receive waiver-funded services, proceed to Step 7.

Step 7. The individual's program plan is completed containing all waiver-funded and other services and support the individual needs in the home and community. The plan must be approved prior to waiver-funded services being authorized.

7a. If waiver and other funding are available for services in the individual program plan, the county authorizes services and funding pursuant to the plan. Proceed to Step 8.

7b. If waiver funding and other funding are not available, the county includes the individual's service needs in the county's PUNS, and refers the individual to other potential service funding sources.

7c. If the individual program plan does not contain services or providers of the individual's choice, the individual or his/her legal representative may request mediation and appeal. Services established on the initial individual program plan may continue as originally approved by the county or designee until the appeal officer makes a decision if the appeal is filed within 10 days of the action. Proceed to Step 8.

7d. If waiver-funded services on the individual program plan are reduced, suspended, or terminated without the individual's consent, the individual or legal representative may file an appeal or request mediation. If the appeal is filed within 10

days of the decision being made known to the individual, services established on the current individual program plan continue until the appeal is resolved. If the appeal is not filed in 10 days, the appeal must be filed in 30 days of the decision to be considered by the Department. Proceed to Step 8.

Step 8. The county conducts an annual recertification of need for waiver services in accordance with MR Bulletin 00-99-14.

8a. If the county determines that the individual no longer qualifies for waiver services, the county completes form MR 251 for the CAO to issue a notice of discontinuance of waiver services together with a notice of right to fair hearing and appeal. A copy of the notice is sent to the county which is responsible for discontinuing services unless an appeal is made. If an appeal is made in a timely fashion, the county should continue to provide services until a decision by the hearing officer is made.

8b. If the county determines that the individual continues to qualify for waiver services, services continue based on the individual's current program plan.

S. Obsolete Bulletins.

MR Bulletin 99-85-02, titled: Beneficiary Choice Under 2176 Waiver, effective January 1, 1985.

MR Bulletin 99-87-08, titled: Revised Fair Hearing Procedures Related to Service Under the 2176 Waiver Program, effective June 10, 1997.