

- c. _____ Hospital
- d. _____ NF (served in hospital)
- e. _____ ICF/NM (served in hospital)

3. A waiver of section 1902(a)(1 0)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

- a. _____ aged (age 65 and older)
- b. _____ disabled
- c. _____ aged and disabled
- d. _____ mentally retarded
- e. _____ developmentally disabled
- f. mentally retarded and developmentally disabled
- g. _____ chronically mentally ill

4. A waiver of section 1902(a)(1 0)(B)of the Act is also requested to impose the following additional targeting restrictions (specify):

a. Waiver services are limited to the following age groups (specify):

_____ birth to age 3 _____

b. _____ Waiver services are limited to individuals with the following disease(s)or condition(s) (specify):

c. _____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d. Other criteria. (Specify):

_____ Infant or toddler needs early intervention services. _____

STATE: _____

DATE: _____

- e. _____ Respite care
- f. _____ Adult day health
- g. X Habilitation
 - _____ Residential habilitation
 - _____ Day habilitation
 - _____ Revocational services
 - _____ Supported employment services
 - _____ Educational services
- h. _____ Environmental accessibility adaptations
- i. _____ Skilled nursing
- j. _____ Transportation
- k. _____ Specialized medical equipment and supplies
- l. _____ Chore services
- m. _____ Personal Emergency Response Systems
- n. _____ Companion services
- o. _____ Private duty nursing
- p. _____ Family training
- q. _____ Attendant care
- r. _____ Adult Residential Care
 - _____ Adult foster care
 - _____ Assisted living

STATE: _____

DATE: _____

s. Extended State plan services (Check all that apply):

- Physician services
- Home health care services
- Physical therapy services
- Occupational therapy services
- Speech, hearing and language services
- Prescribed drugs
- Other (specify):

t. Other services (specify):

- Visual/mobility therapy, Behavior therapy & Visiting nurse.
- Adaptive appliances and equipment
- Personal Support

u. The following services will be provided to individuals with chronic mental illness

- Day treatment/Partial hospitalization
- Psychosocial rehabilitation
- Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care, the Individualized Family Services Plan - IFSP, will be developed by qualified individuals for each individual under this waiver. This IFSP will describe the medical and other services and support (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services and support will be furnished pursuant to the written IFSP. The plan will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the IFSP. FFP will not be claimed for waiver services that are not included in the individual written IFSP.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
- a. When provided as part of respite care that is not a private residence (see definition for State approved settings).
 - b. Meals furnished as part of a program of adult day habilitation services.
 - c. When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means three meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
 - 1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B)
 - 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
 - 3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home- and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

STATE: _____

DATE: _____

- b. The agency will provide for an evaluation of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services, but for the availability of home- and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
- c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
 - 1. Informed of any feasible alternatives under the waiver; and
 - 2. Given the choice of either institutional or home and community-based services.
- d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 43 1, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
- e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated. in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver 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 by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request
- h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.

- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

- a. Yes b. No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

- a. Yes b. No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served under the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care needs of the individuals are met.

Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to persons served under the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of July 1, 2001 is requested.

20. The State contact person for this request is Mel Knowlton who can be reached at (717) 783-5764, or Cathleen Berkey who can be reached at (717) 783-5058.

STATE: _____

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DATE: _____

VERSION 06-95

21 This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services-to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____

Print Name: Feather O. Houstoun

Title: Secretary of Public Welfare

Date: JUN 26 2001

STATE: _____

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DATE: _____

APPENDIX A- ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

_____ The waiver will be operated by _a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy are on file at the Medicaid agency.

_____ The waiver will be operated by the State Office of Mental Retardation (OMR), a separate division within the Single State agency. OMR exercises administrative discretion in the administration and supervision of the waiver and issues, policies, rules and regulations related to the waiver.

STATE: _____

DATE: _____

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

f. X Habilitation:

X Other definition (Specify):

Habilitation consists of a range of services provided for the child by a qualified professional with the participation of the child's family or caregiver.

Services can be provided directly to the child while the family or caregiver is present and participating, or services can be provided as instruction to the family or caregiver to benefit the child's development in everyday life.

For purposes of this waiver, family means a parent, guardian, surrogate parent, or person acting as parent of the child. A caregiver means a person responsible for providing care for the child in the home and community, such as a relative, day care provider, or another adult at the family's discretion.

Instruction to families and caregivers is limited to service techniques, information and, procedures which the family or caregiver needs to support the child's development.

Participation of the family or caregiver is based on their willingness and ability as determined by the family or caregiver, the child's multi-disciplinary team and the provider of service.

Habilitation funded under this waiver must be provided in a natural environment which means the child's home, the home of a relative or friend, or a community setting that is typical for the child's age peers where children without a disability are likely to attend.

Habilitation consists of the assistance and acquisition, retention or improvement of skills related to activities of daily living, such as feeding and dressing, communication with caregivers; orientation and mobility, and social development needed by the child.

Qualifications of the providers are indicated in Appendix B-2. Habilitation, which is provided by therapists and health care professionals, is rendered in accordance with each professional's scope of practice. Habilitation by an early interventionist consists of assistance and instruction in designing learning environments and activities in the home and community to promote the child's acquisition of skills, cognitive process, and social integration.

Habilitation includes the cost of transportation for the provider's travel to the child's home or community services/ activities; consultation with professionals; and participation in the multidisciplinary team process.

Instruction in the application of an assistive device funded through another funding source is an eligible waiver services to the extent that the other funding source does not provide needed family and caregiver instruction in the home and community.

Habilitation providers cannot be limited in any way which would violate the Department's assurance of freedom of choice. No qualified provider of service can be denied access to providing services on the basis of single source contracting or other practices, which would deny or limit a family's choice of qualified providers. In addition, children participating in the waiver will maintain access to all services covered in the State Plan, including EPSDT, with free choice of providers.

The following services and activities are excluded from Federal and State financial participation under this waiver:

- professional Services provided directly to a child without the participation of* a family member or caregiver.
- services rendered in a clinic, provider's office or office area, or outside of a natural environment as defined by this application.
- medical and surgical procedures; the cost of medicine and drugs for these purposes; medical supplies and equipment including wheelchairs, splints and orthopedic devices; and devices necessary to control or treat a medical condition
- personal care services, services provided by a family or caregiver, day care services, respite care services, family aide and preschool services.
- participation of the family or caregiver in service delivery, together with care or services provided by the family or caregiver as a result of the participation.
- assistive technology, including purchase and leasing of computer hardware or software that constitutes assistive technology.

STATE: _____

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DATE: _____

STATE: PENNSYLVANIA

APPENDIX B-2 PROVIDER QUALIFICATION

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, and State Administration Code is referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARDS
Habilitation	Nurse and other Qualified health care professionals	Registered Nurse (RN) Licensed Practical Nurse (LPN) Title 49 Professional and Vocational Standards-Chapter 21 State Board of Nursing	<u>Certification</u> Certified Registered Nurse Practitioner (CRNP) Title 49 Professional and Vocational Standards-chapter 18 State Board of Medicine and Chapter 21 State Board of Nursing	Certified Registered Nurse (CRNP) Title 49 Professional and Vocational Standards-Chapters 16, 17 and 18 State Board of Medicine

All services must conform to the County MH/MR Program Fiscal Manual, 55 Pa. Code Ch.4300, and conditions of the County Grant Agreement for waiver services with the Department.

STATE: _____

DATE: _____

Revised 7/1/99

STATE- PENNSYLVANIA

SERVICE	PROVIDER	LICENSURE	CERTIFICATION/ REGISTERED	OTHER STANDARD
Habilitation	Physical therapist	Licensed physical therapist Title 49 Professional and Vocational Standards- Chapter 40 State Board of Physical Therapy	<u>Registered</u> Physical Therapist Assistant (PTA) Title 49 Professional and Vocational Standards- Chapter 40 State Board of Physical Therapy	
Habilitation	Occupational therapist	Licensed Occupational Therapist (OTR/L) Title 49 Professional and Vocational Standards- Chapter 42 State of Occupational Therapy	<u>Certification</u> Occupational Therapist Assistant (COTA/L) Title 49 Professional and Vocational Standards- Chapter 42 State Board of Occupational Therapy	

STATE: _____

DATE: _____

STATE: PENNSYLVANIA

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Habilitation	Nurse	Registered Nurse (RN) Licensed Practical Nurse (LPN) Title 49 Professional and Vocational Standards-Chapter 21 State Board of Nursing	<u>Certification</u> Certified Registered Nurse Practitioner (CRNP) Title 49 Professional and Vocational Standards-chapter 18 State Board of Medicine and Chapter 21 State Board of Nursing	Certified Registered Nurse (CRNP) Title 49 Professional and Vocational Standards-Chapters 16, 17 and 18 State Board of Medicine
Habilitation	Early Interventionist	Licensed Teacher of the Hearing Impaired Title 49 Professional and Vocational Standards-Chapter 45 State Board of Examiners in Speech/Language and Hearing	<u>Certification</u> Teacher of Special Education Teacher of Early Childhood Teacher of the Visual Impaired, Mentally and/or Physically Handicapped, Hearing Impaired and Speech and Language Impaired PA Department of Education	Early Interventionist-County Certified requiring: -bachelor's degree or above from accredited college or university and one year volunteer experience working directly with children, families or people with disabilities or in counseling. -an associates degree, or 60 credit hours from an accredited college or university and three years work or volunteer experience working directly with families, children, or people with disabilities, or counseling

STATE: _____

Revised 7/1/99

STATE-PENNSYLVANIA

SERVICE	PROVIDER	LICENSURE	CERTIFICATION/ REGISTERED	OTHER STANDARD
Habilitation	Psychologist	Licensed Psychologist Title 49 Professional and Vocational Standards-Chapter 41 State Board of Psychology		
Habilitation	Nutritionist or Dietician		Registered Dietician, or Certified Nutritionist PA Department of Education	
Habilitation	Social Worker	Licensed Social Worker. (LSW) Title 49 Professional and Vocational Standards-Chapter 47 State Board of Social Work Examiner	Social worker with provisional license. Title 49 Professional and Vocational Standards- Chapter 47 State Board of social Work Examiners	

STATE: _____

DATE: _____

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law of regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

- Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.
- A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

STATE: _____

DATE: _____

SECTION 1915(c) WAIVER FORMAT**APPENDIX C-Eligibility and Post-Eligibility****Appendix C-1--Eligibility****MEDICAID ELIGIBILITY GROUPS SERVED**

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. Low-income families with children as described in section 1931 of the Social Security Act.
2. SSI recipients (SSI) Criteria States and 1634 States).
3. Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4. Optional State supplement recipients
5. Optional categorically needy aged and disabled who have income at (Check one):
 - a. 100% of the Federal poverty level (FPL)
 - b. % Percent of FPL which is lower than 100%..
6. The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

STATE: _____

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DATE: _____

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Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

_____ A. Yes X B. No

Check one:

a. X The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community based services in order to remain in the community; or

b. _____ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based Services in order to remain in the community are included in this waiver: (check all that apply):

(1) _____ A special income level equal to:

_____ 300% of the SSI Federal benefit (FBR)

_____ % of FBR, which is lower than 300% (42 CFR 435.236)

\$ _____ which is lower than 300%

(2) _____ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) _____ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4) _____ Medically needy without spenddown in 209(b) States. (42 CFR 43 5.3 3 0)

(5) _____ Aged and disabled who have income at:

a. _____ 100% of the FPL

b. _____ % which is lower than 100%.

(6) _____ Other (Include statutory reference only to reflect additional groups included under the State plan.)

(7) _____ Medically needy (42 CFR 435.320, 435.322, 435,324 and. 435.330)

(8) _____ Other

STATE: _____

DATE: _____

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made **ONLY** for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§ 1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under RULES-§4435.7261924.

REGULAR POST-ELIGIBILITY RULES-§4435.726 and 4435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

STATE: _____

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DATE: _____

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY-41924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of § 1924 of the Act (protection against spousal impoverishment) instead of the posteligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 43 5.726 and 43 5.73 5. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in § 1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual ... while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the § 1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's ,Maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBELITY

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts from the waiver recipient's income.

A. §435.726 --States_which **do not use more restrictive**, eligibility requirements than SSI.

STATE: _____

DATE: _____

a. Allowances for the needs of the

1. individual: (Check one)

A. ___ The following standard included under the State plan (check one):

(1) ___ SSI

(2) ___ Medically needy

(3) X The special income level for the institutionalized (300% of the Federal SSI Benefit Rate)

(4) ___ The following percent of the Federal poverty level): ___ %

(5) ___ Other (specify):

B. ___ The following dollar amount:
\$ ___ *

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. ___ SSI standard

B. ___ Optional State supplement standard

C. ___ Medically needy income standard

D. ___ The following dollar amount:

STATE: _____

DATE: _____

*If this amount changes, this item will be revised.

E. ___ The following percentage of the following standard that is not greater than the standards above: % of standard.

F. ___ The amount is determined using the following formula:

G. X Not applicable (N/A)

3. Family (check one):

A. ___ AFDC need standard

B. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family, of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. ___ The following dollar amount:

\$ ___ *

*If this amount changes, this item will be revised.

D. ___ The following percentage of the following standard that is not greater than the standards above: ___ % of standard.

E. ___ The amount is determined using the following formula:

F. ___ Other

G. X Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435,726.

STATE: _____

DATE: _____

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)____ **209(b) State, a State that is using more restrictive eligibility requirements than SSI.** The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts from the waiver recipient's income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. The following standard included under the State plan (check one):

- (1)____ SSI
- (2)____ Medically needy
- (3)____ The special income level for the institutionalized
- (4)____ The following percentage of the Federal poverty level: ____%
- (5)____ Other (specify):

B. The following dollar amount:
\$ ____*

* If this amount changes, this item will be revised.

C. The following formula is used to determine the amount:

STATE: _____

DATE: _____

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §43 5.217, **enter NA in items 2. and 3.** following.

2. _____ spouse only (check one):

A. ___ The following standard under 42 CFR 43 5.12 1:

B. ___ The medically needy income standard;

C. ___ The following dollar amount:
\$ _____*

*If this amount changes, this item will be revised.

D. ___ The following percentage of the following standard that is not greater than the standards above: _____% of

E. ___ The following formula is used to determine the amount:

F. ___ Not applicable (N/A)

3. _____ family (check one):

A. ___ AFDC need standard

B. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. ___ The following dollar amount:
\$ _____*

*If this amount changes, this item will be revised.

D. ___ The following percentage of the following standard that is not greater than the standards above: % of standard.

E. ___ The following formula is used to determine the amount:

F. ___ Other

G. ___ Not applicable (N/A)

a. ___ Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. ___ The State uses the post-eligibility rules of § 1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a) ___ SSI Standard

(b) ___ Medically Needy Standard

(c) ___ The special income level for the institutionalized

(d) ___ The following percent of the Federal poverty level:
%

(e) ___ The following dollar amount
\$ **

**If this amount changes, this item will be revised.

STATE: _____

DATE: _____

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

(g)____ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

**APPENDIX D
ENTRANCE PROCEDURES AND REQUIREMENTS**

APPENDIX D-1

a. EVALUATIONS OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations)- of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

- Discharge planning team
- Physician (M.D. or D.O.)
- Registered Nurse, licensed in the State
- Licensed Social Worker
- Qualified Professional, as defined in 42 CFR 483.430(a)
- Other (Specify):

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

Every 3 months

Every 6 months

Every 12 months

Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

Physician (M.D. or D.O.)

Registered Nurse, licensed in the State

Licensed Social Worker

Qualified Professional, as defined in 42 CFR 483.430(a)

Other (Specify):

STATE: _____

-30-

DATE: _____

C. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

_____ "Tickler" file

_____ Edits in computer system

_____ Component part of Case Management Service Coordination

_____ Other (specify): Component part of County MH/MR Program responsibility and review in accordance with grant agreement with the Department and a component part of Regional Office of Mental Retardation reviews.

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

___ By the Medicaid agency in its central office

___ By the Medicaid agency in district/local offices

___ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

___ By the case managers

___ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

___ By service providers

X Other (Specify):

The responsible MH/MR Program or its designee, the service coordination unit.

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment criteria to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Revised 6/30/99

Check one:

The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

ATTACHMENT TO DEFINITION OF LEVEL OF CARE ELIGIBILITY

1. LEVEL OF CARE ELIGIBILITY

Each individual who receives home and community services funded under this 1915 (C) Waiver must be eligible for ICF/ORC level of care according to criteria established by the Department and approved by the Health Care Financing Administration (HCFA).

The criteria for an ICF/ORC level of care for infants and toddlers until the age of three are as follows:

- Ia. A licensed psychologist, certified school psychologist, psychiatrist, or licensed physician who practices psychiatry to certify that the applicant or recipient has significantly sub-average intellectual functioning which is documented by either:
 - i) Performance which is more than two standard deviations below the mean of standardized general intelligence test; or
 - ii) Performance which is slightly higher than two standard deviation below the mean of a standardized general intelligence test during a period when the person manifests serious impairments of adaptive behavior.

OR

- Ib. A qualified professional shall certify that the applicant or recipient has other related conditions as defined by 42CFR435.1009 that include cerebral palsy and epilepsy, as well as other conditions, such as autism, other than mental illness, that results in impairments of general intellectual functioning or adaptive behavior, and requires early intervention services and treatment.

AND

- II. A qualified professional who meets criteria established in 42 CFR 483.430 certifies that the applicant or recipient has impairments in adaptive behavior as provided by an assessment of adaptive functioning which shows that the individual has one of the following:

STATE: _____

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i) Significant limitations in meeting the standards of maturation, learning, personal independence, and or social responsibility of his or her age and cultural group evidenced by a minimum of a 50 percent delay in one or 33 percent delay in two of the following developmental areas:

- a. cognitive development
- b. physical development, including vision and hearing
- c. communication development
- d. social development
- e. adaptive development

OR

ii) Substantial functional limitation in three or more of the following areas of major life activity:

- 1. self-care
- 2. receptive and expressive
- 3. learning
- 4. mobility
- 5. self-direction
- 6. capacity for language living
- 7. economic self-sufficiency

AND

III. The applicant's or recipient's conditions are likely to continue indefinitely for a period of at least 12 months. .

STATE: _____

-35-

DATE: _____

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
 - a. informed of any feasible alternatives under the waiver; and
 - b. given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 43 1, subpart E, to individuals who are not given the choice of home or community based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
3. The following are attached to this Appendix:
 - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
 - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
 - d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 43 1, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

The responsible County MH/MR Program

STATE: _____

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DATE: _____

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

- Registered nurse, licensed to practice in the State
- Licensed practical or vocational nurse, acting within the scope of practice under State law
- Physician (M.D. or D. O.) licensed to practice in the State
- Social Worker (qualifications attached to this Appendix)
- Service coordinator

Other (specify):

County MH/MR Program

2. Copies of written plans of care will be maintained for a minimum period of three years. Specify each location where copies of the plans of care will be maintained.

- At the Medicaid agency central office
- At the Medicaid agency county/regional offices
- By Service Coordinators
- By the agency specified in Appendix A
- By consumers

Other (specify):

County MH/MR Program or designee

STATE: _____

DATE: _____

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1. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

Every 3 months

Every 6 months

Every 12 months

Other (specify):

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the IFSP is made subject to the approval of the Medicaid agency:

The IFSP is subject to approval by the County MH/MR Program, the Department's agent, in accordance with conditions and requirements established by the Department's grant agreement with the County MH/MR Program.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The IFSP will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the provider which furnishes each service.
2. A copy of the [IFSP](#) form to be utilized in this waiver is attached to this Appendix.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

- 1. As required by sections 1905 (a) (32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
- 2. As required by section 1902 (a) (27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

- 1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:
 - a. When the individual was eligible for Medicaid waiver payment on the date of service;

- b. When the service was included in the approved plan of care (IFSP);
- c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17) or section 110 of the Rehabilitation Act of 1973.

Yes

No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

All claims are processed through an approved MMIS.

MMIS (Medical Assistance Management Information System) is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

The Medicaid agency will make payments directly to providers of waiver services.

X The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.*

_____ The Medicaid agency will pay providers through the use of limited fiscal agent who functions only to pay waiver claims.

_____ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

*The Department will also utilize the County MH/MR Program as its fiscal agent in its Consolidated and Person/Family Directed Supports Waiver.

Appendix F Attachment

Payment for waiver services will be made to the provider of services by the County MH/MR Program with funds made available by the Department through appropriation by the State legislature.

The County is required to make payments to providers for waiver funded services within the amounts established in the County's waiver allocation(s) based on a cost report which services as the provider's billing for MA eligible services.

Payments are based on individually negotiated rates or charges between the provider and the County MH/MR Program in accordance with 55 PA. Code 4300.

The Department will accept the option to exclude those individuals from the waiver for whom there is a reasonable expectation that home and community-based services would be more expensive than the Medicaid services the individual would otherwise receive in an ICF/MR. This option shall be exercised by the County MH/MR Program based on the availability of state and federal funds and reasonableness of cost provisions contained in the County MH/MR Fiscal Manual, 55 PA Code Chapter 4300. This exclusion shall not prohibit a County MH/MR Program from serving individuals under the waiver whose cost for home and community based services is more than the cost of ICF/MR care as long as the average cost for all waiver recipients is maintained within the State's cost effectiveness limits. The Department will be responsible for maintaining necessary financial controls and structures in this area through its allocation, rebudget and audit processes.

The county is required to ensure that the billings specify the name of the child receiving services or an alternate unique recipient identifier, the name of the MA eligible services the child receives, the number of actual units of MA eligible services provided during the report period, and the approved rate for services. The County MH/MR Program also ensures that services reported are approved in the child's IFSP, and that the child meets eligibility requirements.

The County consolidates the service reports, including any adjustments, and completes a Department of Public Welfare quarterly report. This quarterly report is forwarded to the Department. The report identifies separate funding eligible for FFP. The County makes adjustments to its quarterly report to the Department based on its review of provider reports and notification of exceptions by the Department.

Annual reports are submitted by the County to the Department for waiver services following the close of each fiscal year. These reports reflect actual service costs and utilization reported by providers. Final reconciliation is contingent on receipt of actual provider audited costs, with any subsequent final adjustments made in the following year's reports. The annual reports are prepared in accordance with instructions and on forms provided by the Department.

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Annual audits of County MH/MR programs and providers of service are in accordance with the Single Audit Act. Additional payment and fiscal safeguards are contained in the County's Annual Agreement with the Department.

The provider of service preserves books, documents, and records related to MA eligible services for three years after the MA eligible services are furnished.

The provider of services also retains records, which related to litigation or the settlement of claims arising out of the performance or expenditures to which exception has been taken by the auditors. These records are retained by the provider until such litigation, claims, or exceptions have reached final disposition.

STATE: _____

DATE: _____

APPENDIX G – FINANCIAL DOCUMENTATION

**APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA**

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the wiaver. If there is more than one level (e.g. hospital and nursing facility), complet a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	<u>3,308</u>	<u>3,587</u>	<u>101,167</u>	<u>3,570</u>
2	<u>3,374</u>	<u>3,659</u>	<u>103,190</u>	<u>3,641</u>
3	<u>3,441</u>	<u>3,732</u>	<u>105,254</u>	<u>3,714</u>
4	<u>3,510</u>	<u>3,807</u>	<u>107,359</u>	<u>3,788</u>
5	<u>3,581</u>	<u>3,883</u>	<u>109,506</u>	<u>3,864</u>

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	<u>3,730</u>
2	<u>3,730</u>
3	<u>3,730</u>
4	<u>3,730</u>
5	<u>3,730</u>

EXPLANATION OF FACTOR C:

Check one:

The State will make wiaver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit, which is less than factor C for that waiver year.

STATE: _____

DATE: _____

**APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES**

FACTOR D

LOC:

The July 25, 1994 final regulation defines Factor D as:

“The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.”

The demonstration of Factor D estimates is on the following pages.

APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Service Column A	Waiver Year 1 <u>X</u> 2 3 4 5 #Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
1. Habilitation	3,730	149.94 Qtr. Hrs.	\$22.06	\$12,337,995
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
GRAND TOTAL (sum of Column E):				\$12,337,995
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				3,730
FACTOR D (Divide total by number of recipients):				3,308

AVERAGE LENGTH OF STAY: 196 days

STATE: _____

DATE: _____

APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Service Column A	Waiver Year 1 2 <u>X</u> 3 4 5	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
1. Habilitation		3,730	149.94 Qtr. Hrs.	\$22.50	\$12,583,715
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
GRAND TOTAL (sum of Column E):					\$12,583,715
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:					3,730
FACTOR D (Divide total by number of recipients):					3,374

AVERAGE LENGTH OF STAY: 196 days

STATE: _____

DATE: _____

APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Service Column A	Waiver Year 1 2 <u>X</u> 3 4 5	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
1. Habilitation		3,730	149.94 Qtr. Hrs.	\$22.95	\$12,835,389
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
GRAND TOTAL (sum of Column E):					\$12,835,389
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:					3,730
FACTOR D (Divide total by number of recipients):					3,441

AVERAGE LENGTH OF STAY: 196 days

STATE: _____

DATE: _____

APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Service Column A	1	2 <u>X</u>	3	4	5	Total
	#Undup. Recip. (users) Column B		Avg. # Annual Units/User Column C		Avg. Unit Cost Column D	Column E
1. Habilitation	3,730		149.94 Qtr. Hrs.		\$23.41	\$13,092,656
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
GRAND TOTAL (sum of Column E):						\$13,092,656
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:						3,730
FACTOR D (Divide total by number of recipients):						3,510

AVERAGE LENGTH OF STAY: 196 days

STATE: _____

DATE: _____

APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Service Column A	1	2 <u>X</u>	3	4	5	Total
	#Undup. Recip. (users) Column B		Avg. # Annual Units/User Column C		Avg. Unit Cost Column D	Column E
1. Habilitation	3,730		149.94 Qtr. Hrs.		\$23.88	\$13,355,516
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
GRAND TOTAL (sum of Column E):						\$13,355,516
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:						3,730
FACTOR D (Divide total by number of recipients):						3,581

AVERAGE LENGTH OF STAY: 196 days

STATE: _____

DATE: _____

APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, domiciliary care certified homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Habilitation may be offered in a foster care setting.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following services(s) are furnished in the home of a paid caregiver. (Specify):

Habilitation may be offered in a foster care setting.

The following is an explanation of the method used by the State to exclude Medicaid payment for room and board.

Payments to all families and caregivers are excluded from FFP under this Waiver.

**APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN
UNRELATED LIVE-IN CAREGIVER**

Check one:

The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

See Attachment: Room and board is paid in accordance with 55 Pa. Code, Chapter 6200, titled: Room and Board Charges.

STATE: _____

DATE: _____

APPENDIX G-5

FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

“The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program.”

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

Based on HCFA Form 2082 (relevant pages attached).

Based on HCFA Form 372 for years 1998-1999 of waiver # 0324.04, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

Other (specify):

See attached memorandum for SSI recipients. Total cost divided by recipients is multiplied by 1.05% for COLA.

STATE: _____

DATE: _____

APPENDIX G-6

FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

“The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted.”

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

- Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.
- Based on trends shown by HCFA Form 372 for years 1998-1999 of waiver #0324.01, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.
- Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached (see prior page attachment for 11 ICF/MR recipients).
- Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.
- Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

“The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.”

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation Factor G'.

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

Factor G' is computed as follows (check one):

- Based on HCFA Form 2082 (relevant pages attached).
- Based on HCFA Form 372 for years 1998-1999 of waiver #0324.01, which serves a similar target population.
- Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.
- Other (specify):

APEPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

YEAR 1

FACTOR D: <u>3,308</u>		FACTOR G: <u>101,167</u>
FACTOR D': <u>3,587</u>		FACTOR G': <u>3,570</u>
TOTAL: <u>6,895</u>	≤	TOTAL: <u>104,737</u>

YEAR 2

FACTOR D: <u>3,374</u>		FACTOR G: <u>103,190</u>
FACTOR D': <u>3,659</u>		FACTOR G': <u>3,641</u>
TOTAL: <u>7,033</u>	≤	TOTAL: <u>106,831</u>

YEAR 3

FACTOR D: <u>3,441</u>		FACTOR G: <u>105,254</u>
FACTOR D': <u>3,732</u>		FACTOR G': <u>3,714</u>
TOTAL: <u>7,173</u>	≤	TOTAL: <u>108,968</u>

STATE: _____

DATE: _____
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YEAR 4

FACTOR D: 3,510

FACTOR G: 107,359

FACTOR D': 3,807

FACTOR G': 3,788

TOTAL: 7,317 ≤

TOTAL: 111,147

YEAR 5

FACTOR D: 3,581

FACTOR G: 109,506

FACTOR D': 3,883

FACTOR G': 3,864

TOTAL: 7,464 ≤

TOTAL: 113,370

STATE: _____

DATE: _____

EARLY INTERVENTION

ITF WAIVER RENEWAL – FY 2001-2002 THROUGH FY 2005-2006

	Fiscal Year 1998-1999	Fiscal Year 1999-2000	Projected FY 2000-2001	Projected FY 2001-2002	Projected FY 2002-2003	Projected FY 2003-2004	Projected FY 2004-2005	Projected FY 2005-2006
Allocated Avg Monthly Active Caseload (AAMAC)	8,398	9,321 ¹	10,089 ²	11,239 ³	12,520 ⁴	13,893	15,485	17,260
Allocated Average ITF Waiver Children	548	1,179	1,713	2,126	2,345	2,611	2,911	3,242
Allocated Unduplicated ITF Waiver Chd	965	2,071	3,005 ⁵	3,730	3,730	3,730	3,730	3,730
Inc in Allocated Unduplicated ITF Waiver Chd		1,106	934	725	0	0	0	0
% Allocated Average ITF Waiver Child of AAMAC	7%	13%	17%	19%	19%	19%	19%	19%
% Allocated Average ITF Chd of Allocated Unduplicated ITF Waiver Child	57%	57%	57%	57%	57%	57%	57%	57%
% Allocated Unduplicated ITF Child of AAMAC	11%	22%	30%	33%	30%	27%	24%	22%
Proj Total State/Federal ITF Waiver Svs Allocation			\$9,469,866	\$12,337,996	\$12,583,715	\$12,835,389	\$13,092,656	\$13,355,516

¹ Revised after the close of FY 1999-2000 (Philadelphia only—total was 9,205 + 116 = 9,321).

² Proposed revised allocated avg caseload not yet approved by the Secretary. (Originally budgeted at 10,239 in FY 2001-02 carryforward = 9,205 + 1,034.)

³ FY 2000-01 carryforward budget request included an additional 1,034 children during FY 2000-01 [based on EIRS data] to a revised total of 10,239. Because the projected allocated monthly avg caseload for FY 2000-01 is 10,089 (150 less than budgeted), total is revised to 11,239 in FY 2001-02; an increase of 1,150 children (budgeted increase) over FY 2000-01.

⁴ Based on percentage increase in AAMAC from FY 2000-2001 to 2001-2002 – 11.4% x 11,239 = 1,281. 1,281 + 11,239 = 12,520 in FY 2002-03.

⁵ Proposed region recommended revised allocated unduplicated ITF Waiver children (2nd rebudget adjustment) not yet forwarded to the Secretary—due to lack of State funds. (Third year of approved waiver application included 4,012 unduplicated children.)

NOTE: Ms. Thaler recommended that Year 1 through 5 show no growth in unduplicated children (3,730 year 1 through 5). FY 2002-03 through FY 2005-06 budgeted dollars revised based on Dana Olsen's projections—(2% COLA added to hourly rate for FY 2002-03 (based on FY 2001-02 hourly rate) in FY 2002-03 through FY 2005-06—per Mark Weaver. The # of units of service remains the same throughout the application years.