DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations

SWIFT #061020154030

June 23, 2016

Nancy Thaler, Deputy Secretary
Department of Human Services
Office of Developmental Programs
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Dear Ms. Thaler:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) quality assessment review of the Pennsylvania Consolidated Waiver, CMS control number 0147. This waiver serves individuals age three and older who have a diagnosis of intellectual disability, require active treatment, and meet intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care.

The waiver, authorized under the provisions of 1915(c) of the Social Security Act, provides the following home and community-based services: Education Support Services, Home and Community Habilitation (Unlicensed), Homemaker/Chore, Licensed Day Habilitation, Prevocational Services, Residential Habilitation, Respite, Supported Employment - Job Finding and Job Support, Supports Coordination, Nursing, Therapy Services, Supports Broker Services, Assistive Technology, Behavioral Support, Companion, Home Accessibility Adaptations, Specialized Supplies, Transitional Work Services, Transportation, and Vehicle Accessibility Adaptations.

The report identifies the findings for each assurance, the evidence supporting our conclusions, and recommendations. Pertinent information from Pennsylvania's response to the draft report's recommendations has been incorporated into the final report.

CMS found the State to be in compliance with the following assurances:

State Conducts Level of Care Determinations Consistent with the Need for Institutionalization
Service Plans are Responsive to Waiver Participant Needs
Qualified Providers Serve Waiver Participants
Health and Welfare of Waiver Participants
State Medicaid Agency Retains Administrative Authority over the Waiver Program
State Provides Financial Accountability for the Waiver

The final waiver assessment report is releasable to the public.

Finally, we would like to remind you to submit the renewal package for this waiver to the CMS Central and Regional Offices at least 90 days prior to the expiration of the waiver on June 30, 2017.

We want to extend our sincere appreciation to the Office of Developmental Program staff who assisted in the process and provided information for this review. If you have any questions, please contact Talbatha Myatt at (215) 861-4259.

Sincerely,

Francis T. Mccullough -S

Digitally signed by Francis T. Mccullough -S
Date: 2016.06.23 09:53:58 -04'00'

Francis McCullough
Associate Regional Administrator

Enclosure

cc: Nancy Thaler, ODP (electronic copy)
Julie Mochon, ODP (electronic copy)
Daphne Hicks, CMCS (electronic copy)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region III

FINAL QUALITY REVIEW REPORT

Home and Community-Based Services Waiver Review
Commonwealth of Pennsylvania Consolidated Waiver
Control # 0147
June *23*, 2016

Home and Community-Based Services
Waiver Review Report

Executive Summary:

The Commonwealth of Pennsylvania's Consolidated Home and Community-Based Services Waiver for individuals with intellectual disabilities provides home and community-based services (HCBS) targeted to individuals with intellectual disabilities aged three and older who require the level of care provided by an intermediate care facility (ICF) for the intellectually disabled. The latest CMS 372 Report, for the waiver year ending June 30, 2013, indicated that the Waiver served 16,647 individuals at an average annual per capita cost of $99,156.

The Centers for Medicare & Medicaid Services (CMS) approved the Consolidated Waiver for renewal of a five-year term effective July 1, 2012. This report contains a quality review of the first three years of the renewal period, from July 2012 through June 2015. These three years coincide with State Fiscal Years (SFY – July 1 to June 30), and data are presented by SFY throughout the report. The Department of Human Services (Department), as the State Medicaid agency, retains authority over the administration and implementation of the Consolidated Waiver. The Office of Developmental Programs (ODP), as part of the State Medicaid Agency, is responsible for the development and distribution of policies, procedures, and rules related to Waiver operations. An Administrative Entity (AE) is a County Mental Health/Intellectual Disability (MH/ID) Program or a non-governmental entity with a signed agreement with ODP to perform operational and administrative functions delegated by ODP related to the approved Consolidated Waiver. The AE Operating Agreement establishes the roles and responsibilities of AEs with respect to functions delegated to them for program administration.

The Centers for Medicare & Medicaid Services (CMS) conducted the current review of the waiver program in accordance to 42 CFR 441.302 and instructions in the May 28, 2004 (and February 6, 2007 update) Interim Procedural Guidance. We requested the Commonwealth of Pennsylvania to provide evidence to CMS to substantiate that the waiver is being administered in accordance with the terms of the approved Section 1915(c) waiver and that the specified assurances are met. The review was completed via a desk review of the materials submitted and ongoing communication with the ODP.

The CMS completed the review of information provided by the Commonwealth of Pennsylvania Office of Developmental Programs (ODP). The evidence submitted demonstrates that the Commonwealth of Pennsylvania substantially meets the assurances to administer the waiver.

The current waiver expires on June 30, 2017. The renewal for the Consolidated Waiver is due to CMS by April 1, 2017.

The report findings for each assurance are as follows:

I.State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The state substantially meets the assurance.

II.Service Plans are Responsive to Waiver Participant Needs

The state substantially meets the assurance.

III.Qualified Providers Serve Waiver Participants

The state substantially meets the assurance.

IV. Health and Welfare of Waiver Participants

The state substantially meets the assurance.

V.State Medicaid Agency Retains Administrative Authority over the Waiver Program

The state substantially meets the assurance.

VI.State Provides Financial Accountability for the Waiver

The state substantially meets the assurance.

Introduction:

Pursuant to §1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a state to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve state HCBS waiver programs.

CMS must assess each home and community based waiver program in order to determine that state assurances are met. This assessment also serves to inform CMS in its review of the state's request to renew the waiver.

State Waiver Name: Consolidated Waiver

Operating Agency: Office of Developmental Programs (ODP)

State Waiver Contact: Julie Mochon, MSW, Policy Supervisor
Department of Human Services (717)783-5771

Target Population: Individuals with Intellectual Disabilities

Level of Care: Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)

Number of Waiver Participants: 16,647 reported for waiver year ending June 30, 2013

Average Annual Per Capita Costs: $99,156 reported for waiver year ending June 30, 2013

Effective Dates of Waiver: July 1, 2012-June 30, 2017

Approved Waiver Services: The waiver, authorized under the provisions of 1915(c) of the Social Security Act, provides the following home and community-based services: Education Support Services; Home and Community Habilitation (Unlicensed); Homemaker/Chore, Licensed Day Habilitation, Prevocational Services, Residential Habilitation, Respite, Supported Employment - Job Finding and Job Support, Supports Coordination, Nursing, Therapy Services, Supports Broker Services, Assistive Technology, Behavioral Support, Companion, Home Accessibility Adaptations, Specialized Supplies, Transitional Work Services, Transportation, and Vehicle Accessibility Adaptations.

CMS Contact: Talbatha Myatt, MHSA, MPA
Health Insurance Specialist; 215-861-4259

I. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The state must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/ID-DD.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 C'FR 441.303; SMM 4442.5

The state substantially meets the assurance.

Level of Care Sub- Assurance A - An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Table 2.1 Performance Measure LOC.a.i.a.1.

Performance Measure: Number and percent of new enrollees who have an evaluation for LOC completed prior to entry into the waiver. (Data Source: HCSIS)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of new enrollees who have an evaluation for LOC completed prior to entry into the waiver.* ***Denominator =*** *Number of newenrollees.*	N	1,167	1,233	1,148
	D	1,167	1,234	1,151
	% (N/D)	100%	99%	99%
REMEDIATION DATA				
	Noncompliant	0	1	3
Evaluation completed after entry into thewaiver		0	1	3
Remediated within 30 days		0	1	3
	# Remediated	0	1	3
	% Remediated	N/A	100%	100%

<u>**Details**</u>: ODP generates and distributes to the specific AE, HCSIS reports identifying initial level of care (LOC) compliance and noncompliance data. The reports include a list of exceptions for that AE (any individual for whom a level of care evaluation is not entered into HCSIS as completed prior to the waiver start date). The AE is responsible to review these reports and provide remediation for any situation where a LOC has not been completed prior to waiver enrollment. Remediation will include completion of LOC documents and/or data entered into HCSIS. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

On a monthly basis, ODP generates a 100% sample report of all Consolidated Waiver initial enrollees. ODP reviews for any exceptions (any individual for whom a level of care evaluation is not entered into HCSIS as completed prior to the waiver start date) and conducts follow-up activities with the specific AE. The process of providing feedback is contingent on the factors of the noncompliance. ODP provides guidance and technical assistance as necessary. ODP verifies completion of LOC documents and/or that data has been entered into HCSIS and also assures the AE has established policies and procedures to prevent a recurrence.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates that the sub-assurance has been met.

Level of Care Sub- Assurance B - The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Table 2.2 Performance Measure LOC.a.i.b.1.

Performance Measure: Number and percent of annual LOC determinations completed within 365 days of the prior review. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of LOC redeterminations completed within 365 days of prior review.* ***Denominator =*** *Number of LOC redeterminations that are due.*	N	265	280	275
	D	309	312	305
	% (N/D)	86%	90%	90%
Number of annual LOC redeterminations completelate		43	23	24
Within 30 days		36	20	21
Within 31 – 60 days		1	0	1
Within 61 – 90 days		0	0	1
In greater than 90 days		6	3	1
Number compliant before remediation		308	303	299
% compliant before remediation		99%	97%	98%
REMEDIATION DATA				
Noncompliant requiring remediation		1	9	6
Located missing documentation		1	3	1
Completed LOC determinations which included both legible signatures and dates		0	4	3
Staff retraining		0	2	2
Remediated within 30 days		1	3	5
Remediated within 31-60 days		0	1	0
Remediated within 61-90 days		0	5	0
Remediated in >90 days		0	0	1
# Remediated		1	9	6
% Remediated		100%	100%	100%

Details: As part of the AEOMP record review, ODP evaluates whether annual LOC redeterminations are completed within 365 days of the prior review. AEs must locate or complete LOC evaluations using ODP's standardized forms and process. AEs must enter the LOC redetermination date into HCSIS. AEs are expected to document remediation actions and submit the documentation to ODP within 30 days of the notification.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates that the sub-assurance has been met.

Level of Care Sub- Assurance C - The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Table 2.3 Performance Measure LOC.a.i.c.1.

Performance Measure: Number and percent of LOC initial determinations and redeterminations completed according to ODP policies and procedures. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of LOC initial determinations and redeterminations completed according to ODP policies andprocedures.* ***Denominator =*** *Number of LOC determinations and redeterminations reviewed*	N	310	297	313
	D	314	317	318
	% (N/D)	99%	94%	98%
REMEDIATION DATA				
Noncompliant		4	20	5
Missing documentation was located		3	0	0
LOC redetermination form was created and includes both legible signatures and dates		1	1	1
LOC form was corrected and includes both legible signatures and dates.		0	5	2
QIDP credentials verified/determinationsaccepted		0	14	0
Supervisor trained		0	0	2
Remediated within 30 days		4	10	3
Remediated within 31-60 days		0	4	2
Remediated within 61-90 days		0	6	0
# Remediated		4	20	5
% Remediated		100%	100%	100%

Details: ODP evaluates whether initial LOC determinations and annual LOC redeterminations are completed according to ODP policies and procedures. AEs must locate or complete LOC evaluations using ODP's standardized forms and process in cases where the documentation is not present during the onsite review. AEs are expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

Table 2.4 Performance Measure LOC.a.i.c.2.

Performance Measure: Number and percent of initial LOC determinationsand redeterminations that were completed accurately. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of initial LOC determinations and redeterminations that were completed accurately.* ***Denominator =*** *Number of LOC determinations and redeterminations reviewed.*	N	302	308	308
	D	314	317	318
	% (N/D)	96%	97%	96%
REMEDIATION DATA				
	Noncompliant	12	9	10
Missing documentation of standardized adaptive assessments was located		2	0	3
Medical evaluations were completed and include a recommendation for ICF/ID LOC		9	5	1
Medical evaluations completed with criteria were met, LOC completed, HCSIS amended		1	4	6
Within 30 days		8	5	6
Within 31 – 60 days		4	0	1
Within 61 – 90 days		0	4	1
In greater than 90 days		0	0	2
	# Remediated	12	9	10
	% Remediated	100%	100%	100%

Details: ODP evaluates whether initial LOC determinations and annual LOC redeterminations are completed accurately. AEs are required to locate or complete required documentation that is not present or does not contain the necessary information during the onsite review, including the medical evaluation that documents a recommendation for ICF/ID LOC, a psychological evaluation that contains the results of a standardized general intelligence test that certifies the individual has a diagnosis of intellectual disability/significantly sub-average intellectual functioning, a Standardized Adaptive Assessment indicating impairments in adaptive behavior, and documentation that the individual had conditions of intellectual and adaptive functioning manifested during the developmental period which is from birth up to the individual's 22nd birthday. AEs are expected to document the remediation actions and submit the documentation to ODP within 30 days.

ODP provides feedback as part of the remediation and corrective action plan process. The Administrative Entity Oversight Monitoring Process (AEOMP) is a standardized process designed to collect, compile and analyze data to monitor that the functions delegated to AEs are being performed in compliance with all ODP requirements including waiver assurances and the AE Operating Agreement. A letter is sent to each AE reflecting their performance on all items measured. A Corrective Action Plan (CAP) is required for any AE that exhibits noncompliance in any area. ODP reviews and approves or disapproves the CAP. The AE is expected to implement the approved CAP. ODP validates that corrective actions are taken to remediate each instance of noncompliance within a prescribed timeframe and that other necessary actions are taken to avoid a recurrence. ODP will also provide additional training and technical assistance to support the AE in the completion of corrective action that is required.

ODP uses the AEO database to record AE compliance, remediation and validation of remediation actions. The AEO database automatically tracks the date and time of all activities including

submissions by AEs as well as the date and time of approval by ODP. If a noncompliance is identified, the record is sent to the AE within the AEO database documenting any noncompliance and informing the AE of ODP's expectation that remediation must be completed within 30 days. Within the 30-day timeframe, the AE will respond to the noncompliance by submitting remediation actions within the database and forwarding documentation to ODP for approval. The communication between ODP and the AE is recorded in the AEO database including additional follow-up as needed. When the AE submits all the remediation actions in the database and provides supporting documentation, ODP reviews and approves the remediation actions. When an approval is given, remediation is considered complete.

CMS Findings and Recommendations:

The State provided evidence and documentation that demonstrates the assurance has been met.

II. Service Plans are Responsive to Waiver Participant Needs

The state must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7 Section 1915(c) Waiver Format, Item Number 13

The state substantially meets the assurance.

Service Plan Sub- Assurance a: Service plans address all participants' assessed needs (including health and welfare risk factors) and personal goals, either by the provision of waiver services or through other means.

Table 4.1 Performance Measure SP.a.i.a.1.

Performance Measure: Number and % of waiver participants who have all assessed needs addressed in the ISP through waiver funded services or other funding sources or natural supports. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of participants who have all assessed needs addressed in the ISP through waiver funded services or other funding sources or natural supports.*	N	291	311	300
	D	314	317	318
Denominator = *Number of waiver participants reviewed.*	% (N/D)	93%	98%	94%
REMEDIATION DATA				
	Noncompliant	23	6	18
ISP was amended to reflect all assessed needs		19	5	18
PUNS reflects a change in need		4	0	0
Staff training		0	1	0
Remediated within 30 days		18	6	14
Remediated within 31-60 days		2	0	3
Remediated within 61-90 days		3	0	0
Remediated in >90 days		0	0	1
	# Remediated	23	6	18
	% Remediated	100%	100%	100%

etails: Through the AEOMP, ODP reviews a sample of records to determine if participants have all assessed needs addressed in their ISPs through waiver funded services or other funding sources or natural supports. If a participant's plan does not contain evidence that all assessed needs have been reviewed and/or addressed by the participant and his/her team, the AE will work with the SCO to ensure that the ISP is revised to support the identified assessed needs. The AE will provide ODP with the ISP approval date that reflects the changes made to the ISP that correct the identified noncompliance. Remediation by the AE is expected within 30 days of notification.

If an ISP does not address all the participant's assessed needs, the Supports Coordinator (SC) is responsible for coordinating with the participant, his/her family and other team members to gather the missing information. If a change in waiver services occurs as a result of the team meeting, the ISP Signature Form is signed and the date the meeting occurred is documented. When revisions are completed and the ISP is approved and authorized, the SC is responsible for sharing the revised ISP with the participant and his/her family.

Table 4.2 Performance Measure SP.a.i.a.2.

Performance Measure: Number and % of waiver participants who have had a risk assessment and services and supports in the ISP to mitigate the risk where appropriate. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants who have had a risk assessment.* ***Denominator =*** *Number of waiver participantsreviewed.*	N	314	317	318
	D	314	317	318
	% (N/D)	100%	100%	100%
Numerator (N) = *Number of waiver participants who have had services and supports in the ISP to mitigate risk whereappropriate.* ***Denominator =*** *Number of waiver participantsreviewed.*	N	285	313	296
	D	313	317	317
	% (N/D)	91%	99%	93%
REMEDIATION DATA				
Noncompliant		28	4	21
Risk mitigation strategies are included in the ISP		28	3	21
ISP corrected to reflect more accurate information		0	1	0
Remediated within 30 days		21	1	16
Remediated within 31-60 days		3	2	4
Remediated within 61 – 90 days		4	1	1
# Remediated		28	4	21
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if the required risk assessment has been completed for each participant and that services and supports are included in the ISP to mitigate the identified risk where appropriate. If there is no evidence in the participant's record that a risk assessment has been completed, the applicable AE and SCO will work together to ensure completion and documentation in the ISP of the risk assessment.

If a participant's record does not contain evidence that services and supports have been incorporated in the ISP that mitigate a participant's identified risks, the AE will work with the SCO to ensure that the ISP is amended to include risk mitigation strategies. The AE will notify ODP of the date that the changes were made to the ISP correcting the identified noncompliance. Remediation by the AE is expected within 30 days of notification. This measure looks separately to assure completion of a risk assessment and to assure risk mitigation.

Table 4.3 Performance Measure SP.a.i.a.3.

Performance Measure: Number and % of waiver participants who's ISPs reflect their personal goals. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants whose ISPs reflect their personal goals.* ***Denominator =*** *Number of waiver participantsreviewed.*	N	279	307	297
	D	314	317	318
	% (N/D)	89%	97%	93%
REMEDIATION DATA				
Noncompliant		35	10	21
ISPs amended to reflect outcomes that relate to an identified preference		35	10	20
Waiver participant transferred to newcounty		0	0	1
Remediated within 30 days		29	7	8
Remediated within 31-60 days		1	3	6
Remediated within 61-90 days		1	1	0
Remediated in >90 days		6	0	7
# Remediated		35	10	21
% Remediated		100%	100%	100%

<u>Details</u>: Through the AEOMP, ODP reviews a sample of records to determine if they reflect a participant's identified personal goals by reviewing relevant sections of the ISP. If there is no evidence in an ISP that a participant's identified personal goals have been incorporated, the applicable AE and SCO will work together to ensure that the ISP is amended to include language that reflects the individual's identified personal goals. The AE will notify ODP of the date that the changes were made to the ISP correcting the identified noncompliance. Remediation by the AE is expected within 30 days of notification.

In the event an ISP did not identify the participant's personal goals, the SC is responsible for coordinating with the participant, his/her family and other team members to gather the missing information. If a change in waiver service occurs as a result of the team meeting, the ISP Signature Form is signed and the date the meeting occurred is documented. When revisions are completed and the ISP is approved and authorized, the SC is responsible for sharing the revised ISP with the participant and his/her family.

<u>CMS Findings and Recommendations:</u>

Evidence provided by the State demonstrates that the sub-assurance has been met.

Service Plan Subassurance b - The State monitors service plan development in accordance with its policies and procedures.

Table 4.4 Performance Measure SP.a.i.b.1.

Performance Measure: Number and % of ISPs that are developed consistent with state policies and procedures as described in the approved waiver. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of ISPs that are developed consistent with state policies and procedures as described in the approvedwaiver.* ***Denominator =*** *Number of waiver participantsreviewed.*	N	295	309	293
	D	314	317	318
	% (N/D)	94%	98%	92%
REMEDIATION DATA				
Noncompliant		19	7	25
The ISP was reviewed with the consumer		13	6	21
ODP expectations regarding ISP attendance communicated to provider		6	1	4
Remediated within 30 days		18	4	25
Remediated within 31-60 days		1	0	4
Remediated within 61-90 days		0	3	0
# Remediated		19	7	25
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if ISPs are developed consistent with the State policies/procedures and the ISP Bulletin. ODP will determine if specific criteria have been included in the ISP with remediation expected by AEs when deficiencies in the record are noted. There are six aspects of policy which are evaluated. They include: individual attended the ISP meeting; team members attended the ISP meeting; ISPs where service frequency is indicated; ISPs that include all service and supports; services authorized consistent with service definitions; and AE authorized qualified providers.

The SC is responsible to encourage meaningful participation by the participant and his/her family by informing them of the concepts of Positive Approaches, Everyday Lives and Person Centered Planning. In assisting the participant to understand the ISP process and who participates in it, the SC supports the participant and his/her family in gaining the tools needed to be effective in leading and participating in the development of the ISP. The annotated ISP, which provides a tutorial for the participant and his/her family, is a resource that can be used to assist the participant and his or her family during the ISP process.

ODP uses the AE Oversight Monitoring database to record AE compliance, remediation and validation of remediation actions. The AE Oversight Monitoring database automatically tracks the date and time of all activities including submissions by AEs and the date and time of approval by ODP. If a noncompliance is identified, the record is sent to the AE within the AE Oversight database documenting any noncompliance and informing the AE of ODP's expectation that remediation must be completed within 30 days. Within the 30-day timeframe, the AE will work with the SCO to remediate the deficiency.

The AE responds to the noncompliance by submitting the remediation actions within the database with necessary documentation being forwarded to ODP for approval. The communication between ODP and the AE is recorded in the AE Oversight database including additional follow-up as needed. When the AE submits all the remediation actions in the database and provides supporting documentation, ODP reviews and approves the remediation actions. When an approval is given, remediation is considered complete.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates that the sub-assurance has been met.

Service Planning Sub-assurance c - Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Table 4.5 Performance Measure SP.a.i.c.1.

Performance Measure: Number and % of waiver participants whose Annual ISPs were reviewed, revised & approved within 365 days of the prior Annual ISP. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants whose Annual ISPs were reviewed/revised and approved within 365 days of the prior Annual ISP update date.* ***Denominator =*** *Number of waiver participants reviewed.*	N	246	301	285
	D	271	316	316
	% (N/D)	91%	96%	90%
Number of annual ISPs reviewed and/or approved late		25	15	33
Within 30 days		14	9	20
Within 31 – 60 days		5	4	7
Within 61 – 90 days		2	2	2
In greater than 90 days		4	0	4
Number compliant before remediation		271	316	316
% compliance before remediation		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records that identify any participants for whom annual ISPs are not approved within 365 days of the prior annual ISP. If there is no evidence in a record that the ISP was completed and approved, and that services were authorized by the annual review update date, the applicable AE and SCO will work together to ensure the ISP is completed within 30 days of notification. While not all ISPs are being updated within 365 days, providers and stakeholders are aware of ODP's expectation and are demonstrating at the time of on-site review that ISPs have been updated, with no remediation required.

ODP expects ISPs to be updated within 365 days. Based on the performance of the AE, a focused discussion is held during on-site visits to identify specific barriers to achieving compliance. The AE is expected to remediate each record and in the event an AE performs at or below 86%, AEs will complete a CAP. The AE is also expected to develop strategies to ensure that noncompliance does not recur

Table 4.6 Performance Measure SP.a.i.c.2.

Performance Measure: Number and % of waiver participants whose needs changed and whose ISPs were reviewed/ revised accordingly. (Data Source:AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants whose needs changed and whose ISPs were reviewed/revised accordingly.* ***Denominator =*** *Number of waiver participants reviewed whoseneeds changed.*	N	2	7	46
	D	13	9	55
	% (N/D)	15%	78%	84%
REMEDIATION DATA				
Noncompliant		11	2	9
AE implemented ODP policies/procedures to address the service need		9	1	5
ISP updated		1	1	0
Service need eliminated – no need for change		1	0	2
Provider staff retraining		0	0	2
Remediated within 30 days		10	1	4
Remediated within 31-60 days		0	1	3
Remediated within 61-90 days		1	0	1
Remediated in >90 days		0	0	1
# Remediated		11	2	9
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if ISPs were revised when a change in need was identified that required a waiver service revision. If an ISP is not revised, then the applicable AE and SCO will work together to ensure that correct revisions to the ISP are made. ODP staff persons responsible for AEO record review were trained to identify changes in service need, which resulted in an increased denominator in SY 14/15.

Agency Follow up and Improvement: AEs implemented policies and procedures and retrained staff with a focus on improving documentation of how assessed needs are to be addressed, the content of service notes, PUNS, and ensuring that the loop is being closed. In addition, ODP developed and required two trainings – related to review of content of service notes and documentation for individual monitoring tools to focus on improving continuity within the overall record. In January 2014, ODP conducted a comprehensive review of performance measures and clarified the application of supporting guidelines.

If a participant's needs change, the SC is responsible for coordinating with the participant, his or her family, and other team members to gather information regarding the change in need. If the change in need requires a change to the current amount of service or type of service, a change in provider or in the amount of funding throughout the plan year, the SC will revise the ISP accordingly. The ODP ISP Signature form (DP 1035) is required to be completed at team meetings where service changes result in a critical revision to the ISP.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates that the sub-assurance has been met.

Service Plan Sub-assurance d - Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Table 4.7 Performance Measure SP.a.i.d.1.

Performance Measure: Number and % of ISPs in which services and supports were deliveredin the type, scope, amount, duration and frequency specified in the ISP. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of ISPs in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the ISP.* ***Denominator =*** *Number of waiver participants reviewed.*	N	314	315	312
	D	318	317	318
	% (N/D)	99%	99%	98%
REMEDIATION DATA				
Noncompliant		4	2	6
ISP amended to reflect current services needs		1	1	3
HCSIS Monitoring Form reflects current service delivery		2	1	1
Service delivery resolved within 45 days		1	0	1
Service delivery resolved in greater than 45 days		0	0	1
Remediated within 30 days		3	2	5
Remediated within 31-60 days		1	0	1
# Remediated		4	2	6
% Remediated		100%	100%	100%

Details: Using the sample of Waiver participants drawn through the AEOMP, ODP reviews monitoring conducted by the participant's SC. The ODP standardized individual monitoring tool includes questions evaluating whether services are delivered as specified in the ISP. The tool is completed in HCSIS. In any instance where the SC identifies a concern regarding service delivery, and the issue remains unresolved, the applicable AE will work with the SCO to resolve the situation. Resolution can include but is not limited to changes in service provider, resumption of services at required frequency, team meetings, or changes in service schedule.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates that the sub-assurance has been met.

Service Plan Subassurance e - Participants are afforded choice: between waiver services and institutional care, and between/among waiver services and providers.

Table 4.8 Performance Measure SP.a.i.e.1.

Performance Measure: Number and % of new enrollees who are afforded choice between waiver services and institutional care. (Data Source: HCSIS)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of new enrollees who are afforded choice between waiver services and institutional care (Service Preference Choice or Form 457 Effective Begin Date on or Before Waiver Begin Date).*	N	1,149	1,210	1,149
	D	1,149	1,211	1.151
Denominator = *All new enrollees.*	% (N/D)	100%	99%	99%
REMEDIATION DATA				
Noncompliant		0	1	2
HCSIS was updated to demonstrate that new enrollees were offered choice between waiver services and institutional care		0	1	2
Remediated within 30 days		0	1	2
# Remediated		0	1	2
% Remediated		N/A	100%	100%

Details: On a monthly basis, ODP generates and distributes to the specific AE, HCSIS reports including a list of exceptions for that AE (any individual for whom service delivery preference is not entered into HCSIS as required prior to the Waiver start date). The AE is responsible to review these reports and provide remediation for any situation where Service Delivery Preference has not been completed and/or the date has not been recorded prior to Waiver enrollment. Remediation will include completion of Service Delivery Preference documents and/or data entry into HCSIS. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

The variance of new enrollees is dependent on turnover capacity as well as the Governor's budget initiatives to support additional capacity in the Consolidated Waiver. For example, in SFY13-14 ODP received funding to support 400 additional capacity in the Consolidated Waiver in order to serve individuals who had aging caregivers and met emergency criteria.

Table 4.9 Performance Measure SP.a.i.e.2.

Performance Measure: Number and % of waiver participants whose records document choice between and among services was offered to the participant/family. (Data Source:AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants whose records document choice between/among services was offered to the participant/family.* ***Denominator =*** *Number of waiver participants reviewed.*	N	299	308	310
	D	314	315	318
	% (N/D)	95%	98%	97%
REMEDIATION DATA				
Noncompliant		15	7	8
Documentation was located		6	3	5
ISP Signature Page, box 3, was completed		7	3	3
SCO training		2	1	0
Remediated within 30 days		0	1	5
Remediated within 31-60 days		14	6	3
Remediated within 61-90 days		1	0	0
# Remediated		15	7	8
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if participants/ families have been offered choice between and among services and providers. If there was no documentation that choice between and among services was offered, the applicable AE and SCO will work together to locate or complete the documentation on the ISP Signature Page. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

It is the SC's responsibility to offer choice between and among services and service providers to the participant and his or her family annually or when there is a change in need. If it is found that this information was not provided, the SC must follow up with the individual and his or her family to provide the necessary information. The ISP Signature Form is used to document that choice between and among services and service providers is offered as well as the date follow-up occurred. This activity does not require a revision to the participant's ISP unless the participant exercises the right to choose a different service and/or service provider.

Table 4.10 Performance Measure SP.a.i.e.3.

Performance Measure: Number and % waiver participants whose records document choice between and among providers was offered to the participant/family. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of participants whose records document choice between and among providers was offered to the participant/family.*	N	297	310	310
Denominator = Number of waiver participants reviewed.	D	314	317	318
	% (N/D)	95%	98%	97%
REMEDIATION DATA				
	Noncompliant	17	7	8
Documentation was located		7	3	5
ISP Signature Page, Box 3 and Box 9, is completed		8	3	3
SCO retraining		2	0	0
Confirmed choice was offered by another county		0	1	0
Remediated within 30 days		15	6	5
Remediated within 31-60 days		2	1	3
	# Remediated	17	7	8
	% Remediated	100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if participants/ families have been offered choice between and among services and providers. If there was no documentation that choice between and among services and providers was offered, the applicable AE and SCO will work together to locate or complete the documentation on the ISP Signature Page. The ODP standard signature page (DP-1032) is used to document attendance of all participants in ISP meetings. The signature page includes instructions for use and a checklist to ensure the completion of key service planning elements. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

The AE Oversight database is used by both the AE and ODP to record compliance, remediation and validation of remediation actions. The AEO database automatically tracks the date and time of all activities including submissions by AEs as well as the date and time of approval by ODP. If a noncompliance is identified, the record is sent to the AE within the AE Oversight database, documenting any noncompliance and informing the AE of ODP's expectation that remediation must be completed within 30 days. Within the 30-day timeframe, the AE will respond to the noncompliance by submitting remediation actions within the database with necessary documentation being forwarded for ODP for approval.

The communication between ODP and the AE is recorded in the AE Oversight database including additional follow-up as needed. When the AE submits all the remediation actions in the database and provides supporting documentation, ODP reviews and approves the remediation actions. When an approval is given, remediation is considered complete.

Table 4.11 Performance Measure SP.a.i.e.4.

Performance Measure: Number and % new waiver enrollees and waiverparticipants who are provided information on participant-directed services. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of new waiver enrollees and waiver participants who are provided information on participant-directed services.* ***Denominator =*** *Number of new waiver enrollees and waiver participants.*	N	51	300	307
	D	55	314	318
	% (N/D)	93%	96%	97%
REMEDIATION DATA				
Noncompliant		4	14	11
Documentation was located		0	3	4
ISP signature page was completed		2	5	4
Staff training		2	5	3
Individual transferred		0	1	0
Remediated within 30 days		4	10	5
Remediated within 31-60 days		0	2	5
Remediated in >90 days		0	2	1
# Remediated		4	14	10
% Remediated		N/A	100%	100%

<u>Details</u>: Through the AEOMP, ODP reviews a sample of records to determine if new Waiver enrollees and Waiver participants (at annual ISP meetings) are provided information on participant directed services. If there is no documentation on the ISP Signature Page that information on participant directed services was provided, the applicable AE and SCO will work together to review the option with the person, complete and date the portion of the ISP Signature Page regarding participant directed services, and indicate on the form that the option of participant directed services was reviewed with the Waiver participant outside of an ISP team meeting.

The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification. During 12/13, ODP updated the ISP signature page (checklist) to include Participant Directed Services (PDS); however the update was not released until October 2012 and could not be enforced statewide during this year. Results for SFY 13/14 and forward reflect the inclusion of PDS.

<u>CMS Findings and Recommendations:</u>

Evidence provided by the State demonstrates that the sub-assurance has been met.

III. Qualified Providers Serve Waiver Participants

The state must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.
Authority: 42 CFR 441.302; SMM 4442.4

The state substantially meets the assurance.

Qualified Providers Subassurance A - The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other State standards prior to their furnishing services.

Table 3.1 Performance Measure QP.a.i.a.1

Performance Measure: Number and percent of new providers that meet required licensure and/or certification standards and adhere to other state standards prior to furnishing waiver services. (Enrollment Unit Spreadsheet)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of new providers that meet required licensure and/or certification standards and adhere to other state standards prior to furnishing waiver services.*	N	6	17	42
	D	6	17	42
Denominator = *All new providers that require licensure and/or certification.*	% (N/D)	100%	100%	100%

<u>**Details**</u>: All provider agencies, individual professionals, and vendors that provide services must meet qualification criteria outlined in the Waiver for any new services they intend to provide. AEs are responsible to qualify Waiver providers. To do this, a provider applicant completes an online application and submits required documentation to the qualifying AE. The application and documents are evaluated against objective, standard qualification criteria consistent with the approved waiver. Providers denied qualification status receive written notice of the decision by the qualifying AE informing them what requirements are not met. Providers may resubmit an application for consideration along with additional documentation that such requirements have been met at any time. Once the provider is qualified, they can continue with the enrollment process where the review of qualifications is also a component of enrollment into PROMISe™.

ODP standardized qualification requirements and ODP enrollment practices. Previously, a provider who wanted to enroll with ODP had to go through two Department program offices to become an ODP provider. Now providers deal directly with ODP Provider Enrollment staff, therefore decreasing wait time, confusion and understanding of ODP's qualification and enrollment procedures.

<u>**CMS Findings and Recommendations:**</u>

Evidence provided by the State demonstrates the performance measure has been met.

Table 3.2 Performance Measure QP.a.i.a.2.

Performance Measure: Number and percent of current providers that continue to meet required licensure and/or certification standards and adhere to other statestandards. (Data Source: HCSIS)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of current providers that continue to meet required licensure and/or certification standards and adhere to other state standards.* ***Denominator =*** *All providers that require licensure and/or certification.*	N	392	182	210
	D	392	182	210
	% (N/D)	100%	100%	100%

<u>Details</u>: Current providers are expected to provide documentation to AEs indicating that they have maintained required licensure and/or certification standards, and adhered to other applicable state standards at the required frequency. Beginning in SFY 13/14 the requalification process was transitioned to a two-year cycle. Therefore, the number of providers reflected annually is reduced. Beginning in SFY 14/15, the Department included revalidation requirements as part of the Medicaid Provider Enrollment and Screening process.

The denominator for this measure in each fiscal year shown is the number of qualified providers with an ODP-issued license (Ch. 2380 Adult Training Facilities, Ch. 2390 Vocational Facilities, Ch. 6400 Adult Residential and Ch. 6500 Family Living Homes) and the number of providers who hold other types of licensure, e.g. a nursing license from the PA Department of State. ODP began conducting provider qualification functions on a two-year cycle in SFY 13-14; 100% of all providers are qualified within any given 2-year cycle. The number of providers reported in SFY 13-14 and SFY 14-15 represents 100% of the 392 providers who held an ODP-issued license (Chapters 2380, 2390, 6400, and/or 6500) and the number of providers who hold other types of licensure, e.g. a nursing license from the PA Department of State, as of June 30, 2015.

<u>CMS Findings and Recommendations:</u>

Evidence provided by the State demonstrates the performance measure has been met.

Participant Services Subassurance B - The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Table 3.3 Performance Measure QP.a.i.b.1.

Performance Measure: Number and percent of new non-licensed, non-certified providers that meet initial waiver requirements. (Data Source: EnrollmentUnit Spreadsheet)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of new non-licensed, non-certified providers that meet initial waiver requirements.* ***Denominator =*** *All new non-licensed, non-certified providers.*	N	23	35	46
	D	23	35	46
	% (N/D)	100%	100%	100%

Details: New provider applicants complete an online application and submit required supporting documentation, as identified within the application and also identified in ODP Informational Packet 104-12 to the qualifying AE. New provider qualification applications are reviewed by AEs. Provider applications that do not meet qualification requirements are denied by the AE and are not able to complete the provider enrollment process. Providers who cannot complete the provider enrollment process will receive written notice of the decision, indicating which requirements have not been met. Providers may resubmit an application for consideration along with additional documentation that such requirements have been met.

Table 3.4 Performance Measure QP.a.i.b.2.

Performance Measure: Number and percent non-licensed, non-certified providers that continue to meet waiver requirements. (Data Source: HCSIS)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of current non-licensed, non-certified providers that continue to meet waiver requirements.* ***Denominator =*** *All non-licensed, non-certified providers.*	N	261	112	128
	D	257	112	128
	% (N/D)	98%	100%	100%
Provider (SCO) qualified for service		1	0	0
Multiple MPI numbers consolidated to eliminate duplicate providers		3	0	0
Remediated within 31-60 days		4	0	0
# Remediated		4	0	0
% Remediated		100%	N/A	N/A

Details: Current providers are expected to provide documentation to AEs indicating that they have maintained required licensure and/or certification standards, and adhered to other applicable state standards at the required frequency. Beginning in SFY 13/14 the requalification process was transitioned to a two-year cycle. Therefore, the number of providers reflected annually is reduced.

The terms "non-licensed" and "non-certified" can be used interchangeably. Non-licensed, non-certified providers do not require a professional license or Department-issued certificate of compliance to deliver services. Companion Service, Home and Community Habilitation Unlicensed, and Respite in Home are "non-licensed" and "non-certified" services.

Table 3.5 Performance Measure QP.a.i.b.3.

Performance Measure: Number and percent of providers delivering services to participants who are self-directing that meet initial requirements. (Data Source: ODP Monitoring of Vendor Fiscal Service Provider)		**CY 2012**	**CY 2013**	**CY 2014**
DISCOVERY DATA				
Numerator (N) = *Number of providers delivering services to participants who are self-directing that meet initial requirements.* ***Denominator =*** *All providers delivering services to participants who are self-directing.*	N	73	121	356
	D	73	121	356
	% (N/D)	100%	100%	100%

Details: During the course of the state fiscal year new support service worker (SSW) providers apply to be providers to participants who are self-directing services. These SSW providers are required to meet qualification requirements specified in the Waiver. ODP contracts with a vendor fiscal agency to verify qualifications before the SSW provider is enrolled in the participant directed services program. In 2012, ODP transitioned to a new vendor fiscal agency and increased monitoring of self-directed services. During CY 2013, existing SSW providers who did not meet the end of year qualification requirements were required to enroll as a new provider which is why there was an increase in new SSW providers from CY 2013 and CY 2014.

Table 3.6 Performance Measure QP.a.i.b.4.

Performance Measure: Number and percent of providers delivering services to participants who are self-directing that continue to meet requirements. (Data Source: ODP Monitoringof Vendor Fiscal Service Provider)		**CY 2012**	**CY 2013**	**CY 2014**
DISCOVERY DATA				
Numerator (N) = *Number and percent of providers delivering services to participants who are self-directing that continue to meet requirements.*	N	734	896	962
Denominator = *All current providers delivering services to participants who areself-directing.*	D	734	896	962
	% (N/D)	100%	100%	100%

Details: In 2012 and 2013, the Department received reports from the VF/EA FMS provider (Acumen in 2012, Public Partnerships LLC in 2013 – present) that all SSWs were qualified prior to delivering services. However, when conducting monitoring activities in 2013, the Department discovered that documentation of SSW qualifications by Acumen or PPL was lacking.

As a result, the accuracy of the reports submitted by the vendors was in question. This prompted an in-depth review of qualifications and supporting documentation. The Department also enforced a requirement that no SSW could be paid until the qualification documents were obtained and verified by PPL. Upon completion of the in-depth review, all SSWs paid by PPL were found to be qualified and documentation to support qualification had been obtained and retained.

Support Service Workers (SSWs) who deliver Participant-Directed Services are counted in this performance measure. The SSW provider is re-qualified every two years on a calendar year basis because of Tax implications. The last requalification cycle was completed at the end of CY 2014. The number of qualified SSW providers for CY 2015 is 1,042. This number represents 962 plus any new SSW providers qualified since CY 2014. ODP continues to make an effort to expand Participant Directed Services. The variance in providers noted within this measure represents growth in the number of SSWs who are available to provide services to waiver participants.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates that the sub-assurance has been met.

Qualified Providers Subassurance C - The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.

Table 3.7 Performance Measure QP.a.i.c.1.

Performance Measure: Number and percent of licensed providers that meet training requirements in accordance with state requirements in the approved waiver. (Data Source: Licensing Database)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of licensed providers that meet training requirements in accordance with state requirements in the approved waiver.* ***Denominator =*** *All licensed providers.*	N	812	269	183
	D	854	321	268
	% (N/D)	95%	84%	68%
Licensed providers who did not meet state requirements but complete trainings late and prior to the licensing inspection		N/A	N/A	41
Within 30 days		0	0	8
Within 31 – 60 days		0	0	14
Within 61 – 90 days		0	0	9
In greater than 90 days		0	0	10
Number compliant before remediation		812	269	224
% compliant before remediation		95%	84%	84%
REMEDIATION DATA				
Noncompliant requiring		42	52	44
Located documentation of training		31	27	0
Training provided staff or individual as required		0	0	17
Provider implemented system to ensure training is received timely in the future		11	25	27
Remediated within 30 days		19	39	12
Remediated within 31-60 days		12	10	13
Remediated within 61-90 days		4	3	5
Remediated >90 days		7	0	14
# Remediated		42	52	44
% Remediated		100%	100%	100%

Detail: In July 2012, the Department consolidated all licensing responsibilities under the Bureau of Human Services Licensing (BHSL). As such, oversight of this performance measure is a collaborative effort between BHSL and ODP. BHSL implemented a new enterprise-wide licensing system known as the Certification and Licensing System (CLS) during SFY 13/14. Data in 12/13 and 13/14 reflect a duplicated count of providers if multiple services were provided within a single agency.

The identification of providers in CLS is now unduplicated and according to Master Provider Identifier (MPI). As enhancements to the CLS continued, in SFY 14/15 ODP was able to determine instances where licensed providers completed the required training late but prior to the date of the licensing inspection. This information is provided as part of the discovery data.

The type of licensing database used to collect and store data changed during SFY 13-14. This change is reflected in the data. In SFY 12-13, the data source contained duplicated provider site information and lacked the functionality to drill down to a specific licensed provider agency. This duplicated count is because many licensed provider agencies possess multiple licenses as they render an array of services which require specific licenses. In SFY 13-14, a new enterprise-wide licensing system was implemented. Due to the implementation date, this allowed ODP to drill down to a specific licensed provider agency for a portion of the state fiscal year. In SFY 14-15, the new enterprise-wide licensing system was fully implemented and allowed ODP to determine the total number of unduplicated licensed provider agencies.

ODP determined the total number of licenses issued in SFY 12-13 to be 854 using the available licensing database. ODP conducted a crosswalk between licensing data and provider paid claim data that indicated the number of unduplicated licensed providers to be 314 in SFY 12-13. ODP continued this methodology for SFY 13-14 and determined the number of unduplicated licensed providers to be 319. In SFY 14-15, the enterprise-wide licensing system was fully implemented yielding a result of 268 unduplicated licensed providers at the time of the data extraction. As of February 29, 2016 the total number of unduplicated licensed provider agencies is 284. The variance between the unduplicated numbers of licensed provider agencies in the fiscal years presented is due to the frequency with which BHSL conducts licensing inspections.

Unduplicated # of Provider Agencies Licensed		
SFY 12-13	SFY 13-14	SFY 14-15
314	319	284

The Department conducts annual onsite reviews of licensed providers. The Department notes any regulatory violations, including a provider's failure to meet training requirements, and documents the findings on a Licensing Inspection Summary (LIS). The LIS is submitted to the provider who must return the document to the Department within 10 calendar days of the date of transmission from the Department. Providers must specify how the noncompliance has been corrected or will be corrected. The Department will verify that correction has been made through documentation produced by the provider showing evidence that training has occurred and the date it occurred. The provider must correct the identified violation no more than 90 days from the date the LIS was mailed to the provider.

Repeat noncompliance may affect the provider's license status. If the provider is in compliance as determined by the Department at the time a recommendation for licensure is made (i.e., following verification of compliance as described above), a regular license will be issued to the provider. If the provider is not in compliance with applicable regulations as determined by the Department, the Department may issue a provisional license or refuse to issue a license of any kind.

Agency Follow-Up and Improvement: The combination of enhancements to the consolidated LIS system, updated protocols and procedures, and communication to providers has improved the integrity of data available to inform this measure. ODP created an Informational Memo informing providers that documentation of remediation is now being reviewed and a provider could be in danger of being sanctioned if the items needed to validate that remediation occurred are not submitted to licensing staff. Sanctions may include issuing a provisional license, non-renewal or revocation of license.

Table 3.8 Performance Measure QP.a.i.c.2.

Performance Measure: Number and percent of non-licensed providers (including SCOs) that meet training requirements in accordance with state requirements in the approved waiver. (Data Source: Provider Monitoring)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of non-licensed providers (including SCOs) that meet training requirements in accordance with state requirements in the approved waiver.* ***Denominator =*** *All non-licensed providers (including SCOs).*	N	166	136	129
	D	215	162	163
	% (N/D)	77%	84%	79%
REMEDIATION DATA				
Noncompliant		39	26	34
Staff Trained		34	22	30
Documentation developed/Missing documentation located		1	3	0
Provider voluntarily discontinued services		1	1	3
Provider services "not qualified"		1	0	0
Provider or Staff terminated		2	1	0
Remediated within 30 days		26	20	21
Remediated within 31-60 days		9	4	10
Remediated within 61-90 days		1	0	3
Remediated >90 days		3	2	0
# Remediated		39	26	28
% Remediated		100%	100%	100%

Details: Through the provider monitoring process, on a two-year cycle, AEs conduct on-site reviews of 100% of providers using the standardized monitoring tools developed by ODP. AEs review training records of the last 10 direct support staff members who were hired by each provider during the prior fiscal year. Through the supports coordination organization (SCO) annual monitoring process, ODP conducts on-site reviews of 100% of the SCOs using the standardized monitoring tools developed by ODP.

ODP reviews the training records for all SCs and SC supervisors with a waiver caseload to determine that they attended and completed all required trainings.

If the required staff training is not documented in the record, ODP or the applicable AE will notify the provider and the provider must locate missing documentation or ensure that training is provided within 30 days. The remediation for this process will occur as outlined in the

ODP-established corrective action process.

<u>Agency Follow up and Improvement</u>: The implementation of a Provider Applicant orientation training which will begin in January 2016 includes a component to reinforce ODP expectations for SSWs to understand each participant's ISP and support them in achieving their goals.

ODP continues with a close oversight and review of non-licensed providers to ensure adequate staff training exists at the provider level and that this training is received and completed by all newly hired staff members. This allows ODP to continue with a systematic plan for improvement. To date, efforts have focused on development and standardization of monitoring tools and enhancement of data collection and gathering to produce reports. ODP has developed a standardized termination/sanction process that is now being used as a result of previous recommendations for improvement.

ODP has communicated this standardized process via Informational Memo #062-15, issued July 31, 2015. "Enforcement Actions against Noncompliant ODP Intellectual Disability Waiver Providers" details sanctions that may be taken based on ODP's authority in the 55 Pa. Code Chapter 51 regulations. ODP has also established a sanction policy to articulate actions that may be taken in the event of repeat non-compliance. These sanctions include withholding, disallowing, suspending or recouping payment or future payment, disallowance of new service locations, services or newly-enrolled individuals.

A detailed review of monitoring results from this current provider monitoring cycle will be completed to inform additional areas that need improvement, collaboration with AEs, and training.

<u>CMS Findings and Recommendations:</u>

Evidence provided by the State demonstrates the sub-assurance has been met.

IV. Health and Welfare of Waiver Participants

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.
Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

The state substantially meets the assurance.

ODP uses a comprehensive electronic, internet-based reporting solution for incident management known as the Home and Community Services Information System (HCSIS). All provider entities use HCSIS to report incidents to ODP and the AEs. The ODP incident management lifecycle contains an initial notification process (known as the first section submission), investigation if warranted, final notification process (known as the final section submission), and approval process (known as the closure of the incident) as outlined in Incident Management Bulletin 6000-04-01. When an event occurs, or is alleged to have occurred, that is considered an incident per policy, the reporting entity must submit the first section of the incident report to ODP and the AE within 24

hours of discovery or recognition.

This first section of the incident report includes a description of the event, incident categorization, as well as the action taken to ensure the health and safety of the individual. Once the initial notification is submitted, ODP and the AE will review the incident first section to ensure that prompt action was taken to protect the participant's health, safety, and rights.

Certain categories of incidents are considered *critical incidents*. Critical incidents are incidents that require an investigation to be completed by an ODP certified investigator. Critical incidents are events of abuse, neglect, misuse of funds, rights violations and death. Misuse of funds and rights violations are considered exploitation. As part of the investigation, an investigator must take the first witness statement within 24 hours of being assigned an investigation. The investigator must also complete all witness interviews within 10 days of being assigned the investigation. The investigation and a final investigation determination (either confirmed or not confirmed) must be completed within 30 days. These are the ODP investigation standards (measured as part of H&W a.i.4).

An incident report is considered *finalized* when the reporting entity submits the final section of the incident report to ODP and the AE. Where appropriate, the final section of the incident will include the investigation determination as well as the corrective actions that were carried out or planned in order to mitigate and prevent the reoccurrence of the incident. All incident reports must be finalized within 30 days from the date of discovery or recognition or the incident report is not considered timely. If the reporting entity cannot finalize the incident report within 30 days due to circumstances beyond their control, the provider entity can input an extension notification. When the need for extension is submitted, the reporting entity is obligated to adhere to the extension deadline otherwise the finalization of the incident report is not considered timely.
When the reporting entity finalizes an incident report, ODP and the AE perform a review of the incident report within 30 days from the date of finalization. ODP and the AE review and make a determination regarding the investigation, corrective actions, and other pertinent information to ensure that the incident was managed effectively.

Table 5.1 Performance Measure HW.a.i.1.

Performance Measure: Number and percent of critical incidents in which prompt action (demonstrated within 24 hours) is taken to protect the participant's health, safety and rights. (Data Source: Incident Management Log) Data Pull September, 2015		SFY 12-	SFY 13-	SFY 14-15
DISCOVERY DATA				
Numerator (N) = *Number of critical incidents in which prompt action is taken to protect the participant's health, safety and rights.*	N	5,576	5,988	5,669
Denominator = *Number of critical incidents.*	D	5,565	5,988	5,669
	% (N/D)	99%	100%	100%
REMEDIATION DATA				
Noncompliant		11	0	0
Documentation completed		11	0	0
Remediated within 24 hours		11	0	0
# Remediated		11	N/A	N/A
% Remediated		100%	N/A	N/A

Details: Both ODP and AEs review critical incidents within 24 hours of entrance into HCSIS. In any incident reviewed by ODP staff when it is not clear that adequate or prompt action has been taken to protect the participant's health, safety and rights, ODP will notify the AE that day (or the next business day if the incident was reviewed during non-work hours) to ensure that appropriate action relevant to the incident type has been taken. The AE will work with the provider to ensure that action has been undertaken to protect the participant's health, safety and rights and submit notification to ODP documenting what remediation actions occurred within 24 hours. The numerator for HWa.i.1 includes a review of all incidents (as opposed to solely critical incidents) as all incident report first section submissions must outline the prompt action taken by the reporting entity to protect the health, safety, and rights of the individual.

As part of the first section review completed by ODP and AE, if it is discovered that prompt action was not taken by the reporting entity to protect the health, safety, and rights of the individual, ODP and/or the AE will communicate with the reporting entity and direct action so that remediation occurs within 24 hours of discovery by ODP or the AE. This process ensures the health and safety of the individuals served, while performing administrative authority duties specific to the management of incidents.

Participants are afforded the opportunity to file grievances about any issue or complaint with ODP or the service provider. Participants can communicate an issue or complaint to ODP via the ODP Customer Service Line or the Department of Human Services website. All complaints and grievances are logged into a database and referred to ODP regional or central office staff for resolution. In addition, provider agencies are required by policy to develop grievance procedures that explain how the agency will document, respond and resolve grievances.

Table 5.2 Performance Measure HW.a.i.2.

Performance Measure: Number and percent of AEs that review incidents within 24 hours of the report. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of AEs who review incidents within 24 hours of the report.* ***Denominator =*** *Number of AEs.*	N	45	46	46
	D	48	48	48
	% (N/D)	94%	96%	96%
REMEDIATION DATA				
Noncompliant		3	2	2
AE reviewed incidents		3	2	2
Remediated within 48 hours		2	1	0
Remediated in greater than 72 hours		1	1	2
# Remediated		3	2	2
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP evaluates incidents filed for participants in the sample to ensure timely review by the AE. ODP documents the timeframe within which remediation action has occurred or will be completed by the AE. ODP requires the AE to develop a

Corrective Action Plan to prevent future occurrences. A single instance of non-compliance results in a non- compliance for the AE.

Table 5.3 Performance Measure HW.a.i.3.

Performance Measure: Number and percent of critical incidents finalized within the required time frame (30 days). (Data Source: HCSIS)		**SFY 12-13** As of August 2013	**SFY 13-14** As of August 2014	**SFY 14-15** As of Sept. 2015
DISCOVERY DATA				
Numerator (N) = *Number of critical incidents finalized within the required time frame.*	N	3,186	3,607	4,116
Denominator = *All critical incidents.*	D	5,281	5,898	5,446
	% (N/D)	60%	61%	76%
REMEDIATION DATA				
Noncompliant		2,059	2,291	1,330
Provider finalized critical incident in HCSIS		2,059	2,291	1,330
Remediated within 30 days		1,390	1,562	1,034
Remediated within 31-60 days		362	355	196
Remediated within 61-90 days		157	158	51
Remediated in >90 days		186	216	15
# Remediated		2,095	2,291	1,330
% Remediated		100%	100%	100%

<u>Details</u>: ODP staff monitors a monthly report of critical incidents that are not finalized within 30 days and have no extension filed. This information is provided to AEs who contact providers to determine why incidents have not been finalized and why extensions have not been filed. If a provider does not finalize a critical incident within the required timeframe, the provider must finalize the incident within 5 days or file an extension request, if there are circumstances which support the need for an extension.

This measure is a subset of incidents identified in HW.a.i.1 and focuses on all critical incidents that have been finalized as of the date of the data extraction.

<u>Agency Follow up and Improvement</u>: Actions taken over time have contributed to improvement in SFY 14/15 and that improvement is expected to continue moving forward. ODP will continue to expect AEs to monitor provider performance in finalizing critical incidents using a management level report that provides 100% review of all incident submission deadlines. This report supplements the Incident Management Process Status reports used daily. A monthly "aging incidents" report will continue to be reviewed at regional risk management meetings with AEs for providers within their scope of oversight authority.
As part of the improvement strategy, ODP added questions to the provider monitoring tool and process that assess the provider's performance regarding compliance with the timely finalization of incident reports. Providers that have a low compliance percentage are now issued a corrective action plan and asked to develop an internal policy and procedure to increase their compliance.

Informational Memo #025-15 regarding the importance of timely finalization of incidents was

issued 3/27/15 to reinforce the requirements for finalizing an incident report within a 30 day timeframe or filing an extension if the 30 day timeframe cannot be met.

During SFY 14/15, ODP has worked to transition from HCSIS to an Enterprise Incident Management (EIM) system which presents an opportunity for more complete documentation of incidents and timeframes for resolution. The transition is planned for January 2016. In EIM, a dashboard report will serve as a mechanism for incident point persons and certified investigators to more easily manage tasks, in an effort to ensure timely finalization of incidents. The dashboard will provide a summary of the user's workload, and allow the user to view and manage tasks from one screen. A summary of the incidents in need of a user's attention will be among the first items displayed when a user logs-on to the system. Incidents will be grouped by submission and finalization timeframes so that users will know the items require their immediate attention. AE incident reviewers will have a dashboard that details the specific incidents in need of finalization. This tool will help AEs conduct oversight authority activities and assist them with determining which providers may be in need of technical assistance in order to comply with this requirement.

The state issued an informational memo on 3/27/15 that impacted the performance compliance by reminding stakeholders of the requirements established in policy. In addition, the Southeast region targeted technical assistance to Administrative Entities that focused on provider performance.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance with Performance Measure HW.a.i.3.

Table 5.4 Performance Measure HW.a.i.4.

Performance Measure: Number and percent of AEs that completed investigations inaccordance with ODP standards. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of AEs that completed investigations in accordancewith ODP standards.* ***Denominator =*** *Number of AEs reviewed.*	N	18	17	30
	D	40	42	45
	% (N/D)	45%	41%	67%
REMEDIATION DATA				
Noncompliant		22	25	15
Certified Investigator is counseled as appropriate to ODP standards		16	18	11
Certified Investigator is retrained as appropriate to ODPstandards		6	7	1
Monitoring protocol submitted and accepted		0	0	1
AE staff directed to use ALERT system in HCSIS		0	0	1
Electronic tickler developed by AE		0	0	1
Remediated within 30 days		21	20	12
Remediated within 31-60 days		1	2	3
Remediated within 61-90 days		0	3	0
# Remediated		22	25	15
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of investigations completed by AEs to determine if ODP investigation standards were met. If ODP expectations were not met, AEs will initiate remediation which may include counseling and/or retraining of certified investigators. Documentation of remediation actions must be submitted to ODP within 30 days. As part of the investigation, an investigator must take their first witness statement within 24 hours of being assigned an investigation. The investigator must also complete all witness interviews within 10 days of being assigned the investigation. The investigation and a final investigation determination (either confirmed or not confirmed) must be completed within 30-days.

Agency Follow up and Improvement: During SFY 14/15, ODP clarified the application of guidelines for review of this measure. Through analysis, ODP recognizes the need to establish criteria to allow for extenuating circumstances and/or offer opportunity for exception to timeframes in cases such as states of emergency or circumstances beyond the control of the investigator.

Through annual review and analysis of the AE Oversight Monitoring Process and data results by region, ODP recognized the need to allow for extenuating circumstances and/or offer opportunity for exception to timeframes in cases such as states of emergency or circumstances beyond the control of the investigator. ODP is clarifying the monitoring guidelines and retraining expectations.

CMS Findings and Recommendations:
Evidence provided by the State demonstrates compliance with Performance Measure HW.a.i.4

Table 5.5 Performance Measure HW.a.i.5.

Performance Measure: Number and percent of critical incidents, confirmed, by type. (Data Source: HCSIS) **Numerator (N):** Number of Incidents of Abuse, Neglect, Rights Violations, Misuse of Funds, or Death in Provider Operated Setting, respectively **Denominator (D):** All critical incidents, confirmed		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
	Total Number of Critical Incidents, Confirmed **(D)**	3,124	3,347	3,235
Abuse	(N/D) %	861/3,124 27.5%	884/3,347 26.4%	785/3,235 24.2%
Neglect	(N/D) %	1477/3,124 47.2%	1732/3,347 51.7%	1778/3,235 54.9%
Rights Violation (exploitation)	(N/D) %	240/3,124 7.6%	398/3,347 11.8%	357/3,235 11%
Misuse of Funds (exploitation)	(N/D) %	435/3,124 13.9%	211/3,347 6.3%	228/3,235 7%
Death in Provider Operated Setting	(N/D) %	111/3,124 3.6%	122/3,347 3.6%	87/3,235 2.6%

Details: This performance measure is designed to support evaluation of trends and patterns in the occurrence of critical incidents. The number and percent of critical incidents, confirmed, by type is reviewed to identify opportunities for systemic improvement. The denominator reported for this measure represents the total number of critical incidents, confirmed, by type, per state fiscal year. This measure is a subset of HWai3 and focuses only on confirmed critical incidents (incidents of abuse, neglect, exploitation and death).
In addition to the Child Protective Services Law and the Older Adult Protective Services Act, the implementation of the Adult Protective Services Act in July 2014 has established mandatory reporting requirements for Community members (doctors, nurse, EMTs, teachers, bus drivers, etc.) to report suspected abuse, neglect (including abandonment) and exploitation of individuals between the ages of 18 to 59 with an intellectual disability that they see in the community. Since that time, neglect allegations have increased; however, the percent of critical incidents that are confirmed remains consistent with prior years.

Agency Follow up and Improvement: ODP continues to encourage reporting of critical incidents. The number and percent of critical incidents confirmed, by type are reviewed to identify opportunities for systemic improvement. With each critical incident confirmed a corrective action is carried out or planned by the appropriate entity. ODP continues to develop incident management and risk mitigation trainings for all stakeholders and provide targeted technical assistance as needed.

Enhancements were made to the ODP Certified Investigation course. Specifically, the state strengthened the training content related to conducting a preponderance of evidence standard and clarified the definitions of “confirmed, not confirmed, and inconclusive”. In addition, the state continues to enhance the course with best practices. ODP provided education about recognition and reporting to all AEs, supports coordination organizations and providers. In conjunction with the Division of Adult Protective Services, mandatory reporting training was developed and issued to all AEs, supports coordination organizations and providers.

ODP developed and released a series of trainings specific to “Identifying and Mitigating Risk”. These trainings are available to all stakeholders including AEs, supports coordination organizations, provider agency staff, and individuals and families. These trainings focus on practices to help teams assess potential risks, develop and implement risk mitigation strategies, evaluate strategies for effectiveness and success, recognize progress and assess again, and identify if additional strategies are warranted.

CMS Findings and Recommendations:
Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.5 has been met.

Table 5.6 Performance Measure HW.a.i.6.

Performance Measure: Number and percent of critical incidents, confirmed, where corrective actions were carried out or planned by the appropriate entity within the required time frame. (Data Source: HCSIS)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of critical incidents, confirmed, where corrective actions were carried out by the appropriate entity within the requiredtimeframe.* ***Denominator =*** *Number of critical incidents, confirmed, where corrective actions were required.*	N	3,116	3,339	3,231
	D	3,124	3,347	3,235
	% (N/D)	99%	99%	99%
REMEDIATION DATA				
Noncompliant		8	8	4
Clarifying Detail Regarding Corrective Action(s) Added to Report		4	4	3
Additional Corrective Action(s) Added to Report		4	4	1
Remediated within 30 days		4	1	4
Remediated within 31-60 days		3	4	0
Remediated within 61-90 days		1	0	0
# Remediated		8	8	4
% Remediated		100%	100%	100%

Details: The AE and ODP review confirmed critical incidents to ensure that corrective actions resulting from certified investigation are carried out or planned by the appropriate entity within the required timeframe. If corrective actions are not carried out or planned by the appropriate entity within the required time frame, the AE or ODP will follow up to ensure the corrective actions are carried out or planned within 10 days. All remediation steps are entered into the incident report and are subject to final approval by ODP.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.6 has been met.

Table 5.7 Performance Measure HW.a.i.7.

Performance Measure: Number and percent of waiver participants who receivedinformation about reporting abuse, neglect, and exploitation. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants who received informationabout reporting abuse, neglect, and exploitation.* ***Denominator =*** *Number of waiver participants in the sample.*	N	7	279	303
	D	7	313	315
	% (N/D)	100%	89%	96%
REMEDIATION DATA				
Number noncompliant		0	34	12
Documentation was located		0	18	6
ISP Signature Page was completed		0	7	6
SCs completed training		0	9	0
Remediated within 30 days		0	3	2
Remediated within 31-60 days		0	21	8
Remediated within 61-90 days		0	1	2
Remediated in >90 days		0	9	0
# Remediated		0	34	12
% Remediated		N/A	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if participants/ families have been provided information about reporting abuse, neglect and exploitation. If there was no documentation that the information was provided, the AE will work with the SCO to provide the information to the participant/family and complete the required documentation on the ISP Signature Page. In some cases where the information was provided but not documented, the ISP Signature Page is updated. The SC will meet with the individual and/or family to provide information about reporting abuse, neglect, and exploitation. The ISP signature page will be updated to reflect the date the information was reviewed. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days.

During SFY 12/13, ODP updated the ISP signature page (checklist) to include a question to validate the individual was provided information about reporting abuse, neglect and exploitation. Use of the ISP signature page was initiated during SFY 12/13 but not fully implemented that year, explaining the increase in reporting from SFY 12/13 to SFY 13/14 and forward.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.7 has been met.

Table 5.8 Performance Measure HW.a.i.8.

Performance Measure: Number and percent of AEs that maintain documentation ofincident management training. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) *= Number of AEs that maintain documentation of incident management training.* ***Denominator*** *= Number of AEs.*	N	44	47	44
	D	48	48	48
	% (N/D)	92%	98%	92%
REMEDIATION DATA				
	Noncompliant	4	1	4
Documentation is located verifying that IM training has beendone		1	0	0
Documentation that training has been completed is provided		3	1	4
Remediated within 30 days		4	0	4
Remediated within 61-90 days		0	1	0
	# Remediated	4	1	4
	% Remediated	100%	100%	100%

Details: Through the AEOMP, ODP reviews AEs to determine if incident management training has occurred. When documentation of Incident Management training cannot be produced, AEs must complete the training and/or provide documentation that training has occurred and implement a Corrective Action Plan to prevent future noncompliance. AEs are expected to document the remediation actions and submit the documentation to ODP within 30 days.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.8 has been met.

Table 5.9 Performance Measure HW.a.i.9.

Performance Measure: Number and percent waiver participants for whom there wasan unreported critical incident, by type. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants for whom there was an unreported critical incidents, by type of incident.* ***Denominator =*** *Number of waiver participants in the sample.*	N	6	8	12
	D	314	317	318
	% (N/D)	1.9%	2.5%	3.8%
REMEDIATION DATA				
Noncompliant		14	13	22
Number of critical incidents of abuse that were not reported		5	4	9
Number of critical incidents of neglect that were not reported		5	7	5
Number of critical incidents of exploitation that were not reported		4	0	7
Number of other critical incidents that were not reported		0	2	1
Unreported critical incidents filed in HCSIS within 24 hours ofnotification		14	13	22
# Remediated		14	13	22
% Remediated		100%	100%	100%

<u>Details</u>: Through the AEOMP, ODP reviews a sample of participant records to ensure that critical incidents are reported. If it is determined that a critical incident was not reported, ODP will notify the AE immediately. The AE will instruct the provider to enter the information into HCSIS, work with the provider to ensure that action has been undertaken to protect the participant's health, safety and rights and will submit notification to ODP documenting what remediation actions occurred within 24 hours.

The number of unreported incidents is greater than the number of participants with unreported incidents which aligns with the measure; however, in order to ensure the health and safety of all participants, remediation serves to ensure that all identified unreported incidents are filed.

ODP follows the standard incident management process when the unreported critical incident is discovered. This includes follow-up with the participant/family regarding notification of the incident, the outcome of the investigation, and the implementation of all necessary corrective actions. ODP validates remediation through the AEOMP Corrective Action Plan (CAP) process. Remediation strategies include:

- the unreported critical incident is filed in HCSIS within 24 hours.
- the unreported critical incident is remediated through the incident management process.
- the unreported critical incident is referred to appropriate staff for follow-up.

<u>CMS Findings and Recommendations</u>:
Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.9 has been met.

Table 5.10 Performance Measure HW.a.i.10.

Performance Measure: Number and percent of deaths, by cause of death. (Data Source: Mortality Review Database)		**CY 2012**	**CY 2013**	**CY 2014**
DISCOVERY DATA				
Numerator (N) *= Number of deaths, by cause of death.* ***Denominator (D)*** *= All deaths.* ***% = (N)/(D)***	Total Deaths **(D)**	264	271	275
BY TYPE				

	2012 (N)/(D) %		**2013 (N)/(D) %**		**2014 (N)/(D) %**
Heart Disease	58/264 22%	Diseases of Heart	67/271 24.7%	Diseases of Heart	64/275 23.3%
Dementia (including Parkinson's)	45/264 17%	Cancer	25/271 9.2%	Pneumonia, aspiration	23/275 8.4%
Cancer	29/264 11%	Pneumonia, aspiration	20/271 7.4%	Cancer	19/275 6.9%
Pneumonia	23/264 8.7%	Pneumonia	18/27 6.6%1	Pneumonia	19/275 6.9%
Diseases of the lower respiratory tract	15/264 5.7%	Sepsis	14/271 5.2%	Seizure Disorder	9/275 3.3%
Seizure	12/264 4.5%	Diseases of the nervous System	11/271 4.1%	Sepsis	9/275 3.3%
Sepsis	11/264 4.2%	Asphyxiation	10/271 3.7%	Cerebrovascular accident	7/275 2.5%
Diseases of the digestive system	10/264 3.8%	Seizure Disorder	7/271 2.6%	Gastrointestinal	6/275 2.2%
Congenital	9/264 3.4%	Dementia	6/271 2.2%	Diseases of the nervous System	6/275 2.2%
Asphyxia (choking)	8/264 3%	Gastrointestinal	6/271 2.2%	Dementia	4/275 1.5%
Diseases of the vessels (stroke)	7/264 2.7%	Disease of the Respiratory system	5/271 1.8%	Dementia, Alzheimer	4/275 1.5%
Aspiration pneumonia	5/264 1.9%	Aspiration	4/271 1.5%	Disease of the Respiratory system	4/275 1.5%
Renal	4/264 1.5%	Cerebrovascular accident	4/271 1.5%	ACCIDENTAL	3/275 1.1%
Pulmonary embolus	4/264 2.5%	Inanition (Adult Failure To Thrive)	4/271 1.5%	Aspiration	3/275 1.1%
Fall	3/264 1.1%	Unknown	4/271 1.5%	Inanition (Adult Failure To Thrive)	3/275 1.1%
Inanition (adult failure to thrive)	3/264 1.1%	Dementia, Alzheimer	2/271 .7%	Asphyxiation	2/275 .7%
Hemorrhage	2/264 .8%	Sudden Death	2/271 .7%	Cirrhosis	2/275 .7%
Liver Disease	2/264 .8%	Musculoskeletal	1/271 .4%	Diabetes	2/27 .7%
Anaphylaxis	1/264 .4%	Indeterminate	18/271 6.6%	Congenital Hydrocephalous	1/275 .4%
Asthma	1/264 .4%	Blank	43/271 15.9%	Decubiti	1/275 .4%
Car accident	1/264 .4%			Hypoxemia	1/275 .4%
Diabetes	1/264 .4%			Kidney Disease	1/275 .4%
Hydrocephalous	1/264 .4%			Musculoskeletal	1/275 .4%
Myasthenia Gravis	1/264 .4%			Parkinson's	1/275 .4%
Myotonic Dystrophy	1/264 .4%			Shunt Failure	1/275 .4%
Pancreatitis	1/264			Spina bifida	1/275

	.4%				.4%
Thrombocytopenic Thrombotic Purpura (TTP)	1/264 .4%			Unknown	1/275 .4%
Unknown	1/264 .4%			Indeterminate	30/275 10.9%
				Blank	47/275 17.1%

<u>**Details**</u>**:** This performance measure is designed to support evaluation of trends and patterns in the occurrence of deaths. The number and percent of deaths is reviewed to identify opportunities for systemic improvement. The denominator reported for this measure represents the total number of deaths per calendar year.

The causes of death are presented in order to examine findings within the context of CDC National Center for Health Statistics (NCHS) for both the US and PA. The top causes of death are fairly stable across the last three years in terms of numbers and percentage of cause of death – diseases of the heart, cancer, aspiration/pneumonia, and pneumonia. Diseases of the heart include cases where cause of death (COD) on death certificate was *Cardiac Arrest* and where no additional information was available to further clarify the COD. The incidence of most other causes of death is too small to analyze. For CY 2012, comparing ODP mortality findings with the most recent available leading causes of death for the general population (CDC, 2009), dementia and gastrointestinal disorders continue to represent a larger proportion of the causes of death in the Consolidated Waiver population than the general population. While dementia may occur at a higher incidence in certain subpopulations of persons with IDD, there may also be a reporting bias to identify individuals with intellectual disability as having dementia as compared to the general population. Diseases of the heart include cases where COD on death certificate was *Cardiac Arrest* and where no additional information was available to further clarify the COD.

ODP, consistent with general public health practices, utilizes findings to plan health related remediation, health prevention/management and health education/promotion activities designed to help people to live longer and healthier lives as well as improve quality of life overall. However, before such activities can be designed and implemented, data integrity and validity need to be improved.

ODP experienced challenges during this Waiver cycle in designating causes of death as death certificates are not always available and information in the death certificate is not always reliable. Additionally, the mortality review process is time consuming and manual. Further, because some of the COD counts are small, it is difficult to determine to what extent this information is reflective of the causes of death for the PA I/DD population in general.

<u>**Agency Follow up and Improvement**</u>**:** ODP will examine the mortality review process and identify strategies to streamline review that include best practices and are standardized, user- friendly, and support reliable and valid analysis as well as prevention and promotion efforts. ODP will communicate with appropriate medical authorities to provide outreach education regarding the need to correctly complete death certificates by following the CDC Instructions for Completing the Cause-of-Death Section of the Death Certificate (CDC

publication) and the PA DOH Bureau of Health Statistics Research 2012 Death Certificate Registration Manual.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.10 has been met.

Table 5.11 Performance Measure HW.a.i.11.

Performance Measure: Number and percent of deaths of waiver participants examined according to State protocols. (Data Source: Mortality Review Database)		**CY 2012**	**CY 2013**	**CY 2014**
DISCOVERY DATA				
Numerator (N) = *Number of deaths of waiver participants examined according to State protocols.*	N	25	57	47
Denominator = *Number of deaths of waiver participants requiring examination according to State protocols.*	D	25	57	47
	% (N/D)	100%	100%	100%

Details: When ODP discovers that a Waiver participant whose death occurred in a residential setting was not examined according to the state's protocol, ODP follows up with the appropriate entity to ensure the required protocol is carried out within 24 hours and a Corrective Action Plan is developed and implemented to prevent recurrence.

State protocol requires that such agencies contact the coroner when someone who is not receiving hospice services because of a terminal illness dies in their residence. The coroner was called for all of the 25 Waiver participants during calendar year 2012 that were not receiving Hospice services and died in their residence.

Additional focus was expanded to consumers who were residing in a provider operated setting at the time of their death and who were not receiving hospice services at the time, as per state protocol, their deaths were to be reported to the Coroner's office. Providers met this requirement by contacting the coroner at the time of death for all consumers who met these criteria during CY2013 and CY 2014.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.11 has been met.

Table 5.12 Performance Measure HW.a.i.12.

Performance Measure: Number and percent of incidents of restraint where proper procedures were followed, by type of restraint. (Data Source:HCSIS)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of incidents of restraint where proper procedures were followed, by type of restraint.* ***Denominator =*** *Number of incidents of restraint, by type of restraint.*	N	2,404	3,390	2,948
	D	2,408	3,396	2,952
	% (N/D)	99%	98%	99%
REMEDIATION DATA				
Number noncompliant		4	6	4
Staff Retrained on policy		4	6	4
Remediated within 30 days		4	6	4
# Remediated		4	6	4
% Remediated		100%	100%	100%

Details: ODP regulations specify that any Waiver participant who has two emergency restraints within a six month period must have a behavior support plan with a restrictive procedure plan. When ODP discovers that proper procedures were not followed, a behavior support plan with a restrictive procedure plan that meets ODP regulations must be developed, approved and implemented within 30 days.

ODP regional risk managers monitor the type of restraint to ensure that whenever possible, restraints are part of an approved behavior support plan. 93% of all reported restraints were part of an approved plan. Of the emergency restraints which occurred, 99% were physical restraints in 99% of restraints administered. Through the dual diagnosis initiative leads, ODP focuses technical support on assisting providers to apply restraint reduction techniques for participants who experience multiple restraints to better manage risks associated with restrictive interventions.

When a restraint is used, the event is reported as required by ODP's incident management process. This process includes notification to the participant/ family that a restraint occurred. In addition, a debriefing with the participant's team occurs following the use of the restraint to discuss potential antecedents, any least restrictive interventions utilized prior to the application of the restraint, and any updates needed to existing behavior support plans. All updates are based on team meetings which include the participant/family. A copy of the revised plan is provided to the participant/family.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.12 has been met.

Table 5.13 Performance Measure HW.a.i.13.

Performance Measure: Number and percent of medication errors, by type. (Data Source: HCSIS)		**SFY 12-13**	**SFY 13**	**FY -15**
DISCOVERY DATA				
Numerator (N) = *Number of medication errors, bytype.* ***Denominator (D) =*** *All medication errors.* ***%=(N)/(D)***	Total Medication Errors **(D)**	9,(	9,	8,869
BY TYPE				
Omission	(N/D) %	6172/9063 68.1%	6651/9877 67.4%	6073/10885 68.5%
Wrong Dose	(N/D) %	1278/9063 14.1%	1457/9877 14.8%	1251/10885 14.1%
Wrong Form	(N/D) %	2/9063 (02%	2/9877 0.0%	4/10885 0.0%
Wrong Medication – extra dose	(N/D) %	298/9063 3.3%	311/9877 3.2%	252/10885 2.8%
Wrong Medication - discontinued	(N/D) %	158/9063 1.7%	190/9877 1.9%	213/10885 2.4%
Wrong Medication – for another reason	(N/D) %	59/9063 0.7%	44/9877 0.4%	34/10885 0.4%
Wrong Person	(N/D) %	239/9063 2.6%	250/9877 2.5%	222/10885 2.5%
Wrong Position	(N/D) %	0/9063 0%	0/9877 0%	1/10885 0.0%
Wrong Route	(N/D) %	4/9063 (03%	7/9877 0.1%	8/10885 0.1%
Wrong Technique or Method	(N/D) %	13/9063 0.1%	26/9877 0.3%	16/10885 0.2%
Wrong Time	(N/D) %	832/9063 9.3%	930/9877 9.4%	795/10885 9.0%

Details: This performance measure is designed to support evaluation of trends and patterns in the occurrence of medication errors. The number and percent of medication errors is reviewed to identify opportunities for systemic improvement. The denominator reported for this measure represents the total number of medication errors per fiscal year. The average number of remediation activities per medication error/fiscal year was 1.89 for FY 14-15.

There were an additional 15,384 actions taken by the agency to prevent recurrence. The most common types of errors in order of decreasing frequency are omission, wrong dose and wrong time. The most frequently utilized remediation actions included contacting the program supervisor, contacting health care professional, and observing for side effects. The most frequently utilized prevention actions were: providing feedback to the individual employee and providing training and/or retraining.

The increases noted in both the count of medication errors and remediation and prevention activities are attributed to the addition of new information about medication administration best practices integrated into the medication administration training.

Awareness of what constitutes a medication error and the recognition of medication errors result in better reporting. It is not unusual to see increases in the count of medication errors or better reporting following training events.

Agency Follow up and Improvement: ODP will continue to monitor patterns and trends in analysis of types of medication errors, cause, remediation and preventive actions to identify improvement opportunities. ODP will evaluate new information about medication administration best practices to incorporate into both the initial course and on-going medication administration monitoring. ODP will evaluate new information about medication errors to determine causes and contributing factors to develop additional remediation and teaching strategies and continue to update all trainers with findings and recent developments in medication administration best practices.

CMS Findings and Recommendations:
Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.13 has been met.

Table 5.14 Performance Measure HW.a.i.14.

Performance Measure: Number and percent of complaints, by type. (Data Source: Compliant Log)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of complaints, by type.* ***Denominator =*** *All complaints.*	N	76	111	102
BY TYPE				
Abuse of Individual		1/1%	15/13%	8/8%
Administrative Entity		4/5%	8/7%	8/8%
Civil Rights of Individual		0/0%	1/1%	0/0%
Direct Support Staff		11/14%	7/5%	21/22%
Exploitation of Individual		1/1%	3/3%	0/0%
HCBS Waiver		1/1%	1/1%	1/1%
Neglect of Individual		0/0%	3/3%	1/1%
Office of Developmental Programs		6/8%	8/7%	4/4%
Other		5/7%	8/7%	6/7%
Provider Agency		43/57%	50/46%	43/41%
Supports Coordination Organization		4/5%	5/5%	8/8%
Unspecified		0/0%	0/0%	1/1%
Violation of Individual Rights		0/0%	2/2%	1/1%

Details: For purpose of this measure, the Department applies the CMS technical guide definition of "complaint," which is "the formal expression of dissatisfaction by a participant with the provision of a Waiver service or the performance of an entity in conducting other activities associated with the operation of a Waiver." Complaints may be received from program participants, family members and representatives, AEs, providers, advocates, and other interested parties through a centralized customer service line. This performance measure is designed to support evaluation of trends and patterns in the occurrence of complaints. The

number and percent of complaints is reviewed to identify opportunities for systemic improvement. The complaint types shown reflect the type of allegation or the entity against which the complaint is directed.

Upon receipt of a complaint, regional office staff contacts the complainant to acknowledge receipt of the complaint and to collect additional information, unless the complainant is anonymous or did not provide contact information. When comprehensive intake information is received, regional office staff determines whether the complaint should be investigated by ODP or an entity subject to ODP's direct authority (i.e. an administrative entity, supports coordination organization, or provider), or if the complaint should be referred to an external oversight entity, e.g. the Bureau of Human Services Licensing, the Pennsylvania Department of Health, Pennsylvania Adult Protective Services, law enforcement, etc.

In cases where the complaint is investigated by ODP or its subordinate entities, regional office staff provides direction and information to the investigating entity and recommends they follow up with the reporting participant/family. In some cases, depending on the nature of the complaint, the regional office staff follows up with the person reporting to provide the investigation results and/or ensure resolution fully addressed the concerns. In cases where the complaint is referred to an external oversight entity, ODP notifies the complainant that the referral has been made, and that the external entity will notify the complainant of the investigation results in accordance with the entity's policy on follow-up to complainants. Additionally, complainants can and do contact the ODP Customer Service Line to inquire about the status of an investigation. Calls of this type are referred to the investigating region for appropriate response.

CMS Findings and Recommendations:
Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.14 has been met.

Table 5.15 Performance Measure HW.a.i.15.

Performance Measure: Number and percent of complaints resolved within 21 days of receipt. (Data Source: Compliant Log)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of complaints resolved within 21 days ofreceipt.*	N	38	54	95
Denominator = *Number of complaints received.*	D	76	111	102
	% (N/D)	50%	49%	93%
REMEDIATION DATA				
	Number noncompliant	38	57	7
Remediated within 30 days		0	8	2
Remediated within 31-60 days		0	4	2
Remediated within 61-90 days		0	0	2
Remediated in >90 days		0	1	1
Resolution date not recorded		38	44	0
	Remediated	38	57	7
	% Remediated	100%	100%	100%

Details: All complaints were resolved; however, resolution dates were not captured in the log for FY 12-13 and portions of FY 13-14. This identified problem was corrected in FY 14-15.

Agency Follow up and Improvement: The Department is reviewing its complaint intake and response documentation procedures to improve reliability and consistency in measurement in SFY 15-16. Planned objectives include updating the procedures and tools used in the administration of the customer service line. Some complaints could only be resolved via the Department's investigative procedures, which allow for investigation timeframes longer than 21 days. Allowances for extensions in complex cases, and adherence to documentation standards are slated to be addressed in the Department's revised complaint procedures.

The Department is reviewing its complaint intake and response documentation procedures to improve reliability and consistency in measurement in SFY 15-16. Planned objectives include updating the procedures and tools used in the administration of the customer service line. The action plan to achieve this outcome includes the following steps:

- Amending the current Customer Service Line (CSL) Protocol to outline various inquiry types, one of which is Complaints; provide a list of complaint types with definitions, e.g. Dissatisfaction with Administrative Entity, Dissatisfaction with Provider's Performance, Dissatisfaction with Supports Coordination Organization, Dissatisfaction with Waiver Program, Mistreatment of Individual etc.
- Establishing a CSL Protocol that defines how to triage all inquiries to the appropriate source for resolution, e.g. issues already being managed through the Department's Incident Management process.
- Developing documentation standards.
- Establishing a CSL Protocol for the routine monitoring of inquiries to ensure timely resolution.
- Establishing a CSL Protocol that defines when an inquiry is considered closed, and what circumstances, if any, warrant an extension beyond 21 days for resolution to occur (e.g., a person who must be interviewed as part of an investigation is out of the country for an extended period of time).
- Identifying a reliable CSL data system to ensure that all relevant data is captured and reported accurately and timely, and to specifically identify complaints within the larger context of all customer service inquiries.

Revising and reissuing the Customer Service Line Protocol to include, at a minimum:

- Definition of various types of inquiries expected through the CSL and triage of each
- Updated CSL Protocols\Directions for using the new data system described above
- Documentation standards and expectations.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.15 has been met.

Table 5.16 Performance Measure HW.a.i.16.

Performance Measure: Number and percent of providers that ensure waiver participants receive physical exams in accordance with ODP rules. (Data Source: Licensing Data)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of providers that ensure waiver participants receive physical exams in accordance with ODP rules.*	N	812	217	226
Denominator = *Number of providers reviewed.*	D	854	269	259
	% (N/D)	95%	81%	87%
Number of physical exams completed late		N/A	22	33
Within 30 days		N/A	10	14
Within 31 – 60 days		N/A	4	9
Within 61 – 90 days		N/A	5	2
In greater than 90 days		N/A	3	8
Number compliant before remediation		N/A	237	259
% compliant before remediation		N/A	88%	100%
REMEDIATION DATA				
Noncompliant requiring remediation		42	30	0
Missing documentation of physical exam located		31	10	0
Physical exam completed and documentation submitted		11	20	0
Remediated within 30 days		18	13	0
Remediated within 31-60 days		13	9	0
Remediated within 61-90 days		4	3	0
Remediated in >90 days		7	5	0
# Remediated		42	30	0
% Remediated		100%	100%	N/A

Details: In July 2012, the Department consolidated all licensing responsibilities under the Bureau of Human Services Licensing (BHSL). As such, oversight of this performance measure is a collaborative effort between BHSL and ODP. BHSL implemented a new enterprise-wide licensing system known as the Certification and Licensing System (CLS) during SFY 13/14. Data in 12/13 and 13/14 reflect a duplicated count of providers if multiple services were provided within a single agency. The identification of providers in CLS is now unduplicated and according to Master Provider Identifier (MPI).

The Department conducts annual onsite reviews of licensed providers. The Department notes any regulatory violations, including a provider's failure to meet the requirement for Waiver participants to receive annual physical examinations, and documents the findings on a Licensing Inspection Summary (LIS). The LIS is submitted to the provider who must return the document to the

Department within 10 calendar days of the date of transmission from the Department. Providers must specify how the noncompliance has been corrected or will be corrected.

The Department will verify that correction has been made through documentation produced by the provider showing evidence that the physical exam occurred and the date it occurred. The provider must correct the identified violation no more than 90 days from the date the LIS was mailed to the provider.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.16 has been met. Overall, documentation provided by the State demonstrates compliance with the Health and Welfare assurance.

V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program

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

Authority: 42 C'FR 441.303; 42 CFR 431• SMM 4442.6; SMM 4442.7

The state substantially meets the assurance.

Table 1.1 Performance Measure AA.a.i.1.

Performance Measure: Number and percent of AEs that implement monitoring protocols using the ODP standardized monitoring tool. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-**
DISCOVERY DATA				
Numerator (N) *= Number of AEs that implement monitoring protocols using the ODP standardized monitoring tool.* ***Denominator (D)*** *= Number of AEs that delegate or purchase administrative functions.*	N	19	21	27
	D	24	29	31
	% (N/D)	79%	72%	87%
REMEDIATION DATA				
Noncompliant		5	8	4
AE implemented monitoring protocols		4	3	3
AE located documentation to substantiated protocols were implemented		1	5	1
Remediated within 30 days		4	7	3
Remediated within 31-60 days		1	0	1
Remediated within 61-90 days		0	1	0
Remediated in >90 days		0	0	0
# Remediated		5	8	4
% of AEs remediated		100%	100%	100%

Details: The AE Operating Agreement establishes the roles and responsibilities of AEs with respect to functions delegated to them for program administration. There are a total of 48 AEs; however, not all 48 AEs delegate or purchase administrative functions therefore causing the variance of AEs in the denominator per SFY.

AEs may delegate and purchase administrative functions in accordance with the AE Operating Agreement. When AEs delegate or purchase administrative functions, they shall retain responsibility for compliance with the AE Operating Agreement. In addition, AEs are responsible to monitor delegated or purchased administrative functions to ensure compliance with applicable Departmental rules, Waiver requirements, written policies and procedures, and state and federal laws.

ODP receives from each AE annually a list of administrative functions that are delegated or purchased by that AE along with a copy of the monitoring protocol for each delegated or purchased function. On an annual basis, ODP reviews the list of each AE's delegated or purchased functions to verify implementation of the monitoring protocol.

If ODP determines that an AE is not implementing monitoring activities as required by the protocol, the AE will be notified and is expected to complete remediation within 30 days. Remediation can be completed by the AE locating missing evidence that documents their implementation of the monitoring protocol and/or by the AE implementing required monitoring protocols and providing ODP supporting evidence. Evidence may include but is not limited to AE correspondence with the entity that carries out the delegated and/or purchased function containing findings of monitoring, records of on-site visits to the entity or entities involved, and corrective actions taken by the entity or entities involved.

Agency Follow-Up and Improvement: Performance of the AEs demonstrates improvement over time and can be attributed to training and targeted technical assistance provided by ODP regional staff in the areas of non-compliance.

CMS Findings and Recommendations:
Evidence provided by the State demonstrates compliance of Performance Measure AA.a.i.1 has been met.

Table 1.2 Performance Measure AA.a.i.2

Performance Measure: Number and percent of AEs that maintain, safeguard,and provide access to waiver records as per ODP's expectations. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) *= Number of AEs that maintain, safeguard and provide access to waiver records as per ODP's expectations.* ***Denominator (D)*** *= Number of AEs reviewed.*	N	47	46	44
	D	48	48	48
	% (N/D)	98%	96%	92%
REMEDIATION DATA				
	Noncompliant	1	2	4
Documentation located		1	2	4
Remediated within 30 days		1	2	4
	# Remediated	1	2	4
	% Remediated	100%	100%	100%

Details: Through the AEOMP, ODP evaluates whether AEs maintain, safeguard, and provide access to waiver records according to ODP's policies and procedures. If an AE does not maintain, safeguard, and provide access to waiver records according to ODP's policies and procedures, the AE is expected to document remediation actions and submit the documentation to ODP within 30 days. Remediation activities may include locating missing evidence of record retention, establishing secure record storage, and training staff on procedures to safeguard access and confidentiality of records.

Table 1.3 Performance Measure AA.a.i.3.

Performance Measure: Number and percent of waiver participants whose category of needfor services is reviewed/updated in accordance with the Department's policy and form(currently Prioritization of Urgency of Need for Services [PUNS]). (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants whose category of needfor services is reviewed/updated in accordance with the Department's policy and form (currently PUNS).* ***Denominator (D) =*** *Number of waiver participantsreviewed.*	N	8	20	6
	D	20	22	9
	% (N/D)	40%	91%	67%
Number of PUNS updated late (after servicechange)		8	0	0
Within 30 days		1	0	0
In > 90 days		7	0	0
Number compliant before remediation		8	20	6
% compliant before remediation		100%	91%	67%
REMEDIATION DATA				
Noncompliant requiring remediation		0	2	3
PUNS update documentation was located and entered into HCSIS		0	0	2
PUNS update was completed and entered into HCSIS		0	0	1

No need for PUNS	0	2	0
Remediated within 30 days	0	2	3
# Remediated	0	2	3
% Remediated	N/A	100%	100%

Details: Through AEOMP, ODP evaluates AE performance in determining participants' category of need. The Prioritization of Urgency of Need for Services (PUNS) serves to ensure individuals identified for enrollment into the Waiver are assigned a category of need for services in accordance with the Department's policy. ODP generates a report of individuals for whom a category of need for services form (PUNS) has not been completed in a timely manner and makes the report available to AEs monthly. Each AE is responsible to review these reports and work with the applicable SCO to ensure remediation for any situation where a category of need for services form has not been completed and updated within 365 days.

Remediation is expected to occur within 30 days and includes completion of category of need for service forms and entry of the information into HCSIS. AEs must summarize the remediation actions taken and provide information to ODP staff.

Participants who are fully served are not identified in this measure. Only those who have active PUNS as a result of a changing service need are considered, leaving few qualifying cases for consideration. Further review shows the non-compliances identified within this extremely limited sample occurred when PUNS forms were not updated within 365 days during SFY 14/15.

Agency Follow-Up and Improvement: During SFY 14/15, a HCSIS system enhancement has been completed that will enable ODP to track historical updates to the PUNS form in HCSIS. With this enhancement, ODP will be able to produce a 365-day tickler report that identifies all participants and shows their active PUNS status, last update and next update due. In addition, the system enhancement will enable users to identify all 30 day updates due based on change in need, providing an opportunity to monitor participant PUNS status in a more timely fashion. This system alert will replace manual tracking and provide for more accurate and reliable identification of PUNS status. ODP plans to operationalize the use of this HCSIS system enhancement and accompanying reporting in the coming months.

A report showing the last PUNS update date for each individual can now be viewed by month to assist AEs and SCOs to work together to complete PUNS in a timely manner. The following table can also be obtained through the enhancements and presents compliance data for 100% of participants who had an active PUNS due for a 365-day update from July 2015 through February 2016.

Consolidated Waiver July 2015 – February 2016		
PUNS Completed in 365 Days	N	802
Total PUNS Due	D	886
% Complete	% (N/D)	89.5%

To assist SCs to track and complete 30-day updates based on change in need, the PUNS history screen enhancement allows users to view and monitor each individual's PUNS history from date of entry until the individual is no longer in active status with ODP.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure AA.a.i.3 has been met.

Table 1.4 Performance Measure AA.a.i.4.

Performance Measure: Number and percent of eligible applicants having an emergency need or who have been identified as being in reserved capacity status who receive preference in waiver enrollment. Percent = number of eligible applicants having an emergency need or who have been identified as being in reserved capacity status who receive preference in waiver enrollment/number of eligible applicants. (Data Source: Waiver Capacity Management Reports)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of eligible applicants having an emergency need who receive preference in waiver enrollment.* ***Denominator =*** *Number of eligible applicants.*	N	629	503	698
	D	633	503	698
	% (N/D)	99%	100%	100%

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

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure AA.a.i.4 has been met.

Table 1.5 Performance Measure AA.a.i.5.

Performance Measure: Number and percent of waiver participants issued fair hearing and appeal rights in accordance with policies and procedures. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants issued fair hearing and appeal rights in accordance with policies and procedures.* ***Denominator =*** *Number of participants reviewed.*	N	352	342	368
	D	372	352	389
	% (N/D)	95%	97%	95%
REMEDIATION DATA				
	Noncompliant	20	10	21
Documentation is located and/or ISP was updated		11	5	6
Notification completed of Due Process Rights, ISP is updated, entered in HCSIS		5	4	14
ISP signature page updated to reflect notification of Due Process Rights		4	1	1
Remediated within 30 days		17	9	13
Remediated within 31-60 days		3	1	5
Remediated within 61-90 days		0	0	1
Remediated in >90 days		0	0	2
	# Remediated	20	10	21
	% Remediated	100%	100%	100%

Details: Through the AEOMP, ODP determines if waiver participants in the sample were issued rights to fair hearing and appeals when the participant was determined likely to require ICF/ID level of care (for participants enrolled within the last twelve months), at the last annual ISP meeting, and at the time of a service change (if a service was reduced, suspended or denied).

If ODP does not locate documentation to substantiate that due process rights were issued in any of the above circumstances, ODP will instruct the AE to locate missing documentation or, when not available, provide written notification of due process rights to the participant/surrogate. The information is recorded in HCSIS or the ISP Signature Page is completed where applicable with a note acknowledging that the notification is late.

It is the SC's responsibility to inform the participant and his or her family of the participant's due process rights annually and/or any time there is a change in service. The ISP Signature Form is used to document that due process rights were provided to the participant as well as the date contact occurred.

If at any time during the ISP planning year, the AE makes the decision to reduce, suspend, terminate and/or deny a waiver service, the AE is responsible for notifying the participant in writing of the decision. This notification also includes Due Process rights. The AE must keep a copy of the written notice in the participant's file. The AE is expected to document remediation actions and submit the documentation to ODP within 30 days.

<u>CMS Findings and Recommendations</u>:

Evidence provided by the State demonstrates compliance of Performance Measure AA.a.i.5 has been met.

Table 1.6 Performance Measure AA.a.i.6.

Performance Measure: Number and percent of final orders issued by the Department's Bureau of Hearings and Appeals ruled in favor of the appellant and implemented within 30 calendar days of the final order. (Data Source: Service Reviews Database)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of final orders issued by the Department's Bureau of Hearings and Appeals ruled in favor of the appellant and implemented within 30 calendar days of the final order.*	N	1	2	0
	D	1	2	0
Denominator = *Number of final orders issued by the Department's Bureau of Hearings and Appeals ruled in favor of the appellant.*	% (N/D)	100%	100%	N/A

<u>Details</u>: ODP maintains a log of Fair Hearing requests for waiver participants. When a Fair Hearing request results in the Department's Bureau of Hearings and Appeals rendering a decision, that information is recorded in the log along with any required action. AEs must ensure that final orders are implemented within the expected timeframe. If orders are not implemented within expected timeframes, AEs will be required to ensure remediation within five calendar days of notification by ODP. AEs will work with SCOs to revise the ISP if necessary or initiate/continue the service. AEs shall notify ODP of the remediation action that has occurred within 10 days. Of the records reviewed for the three years, three appeals were ruled in favor of the individual. In one case, the individual was provided assistive technology, in one case the individual obtained a physical examination and waiver eligibility was reinstated, and the final case was awarded Home and Community Habilitation Level 3 at an Enhanced Level.

<u>CMS Findings and Recommendations</u>:

Evidence provided by the State demonstrates compliance of Performance Measure AA.a.i.6 has been met.

Table 1.7 Performance Measure AA.a.i.7.

Performance Measure: Number and percent of AEs that qualify providers using qualification criteria as outlined in the current approved waiver. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of AEs that qualify providers using qualification criteria as outlined in the current approved waiver.* ***Denominator =*** *Number of AEs reviewed.*	N	41	44	42
	D	47	46	45
	% (N/D)	88%	96%	94%
REMEDIATION DATA				
Noncompliant		6	2	3
Remediated by collecting documentation that AE qualified provider in accordance with ODP's standardized procedures		6	2	3
Remediated within 30 days		5	2	2
Remediated within 60 days		1	0	1
Remediated		6	2	3
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of provider initial and annual provider qualification applications. ODP ensures that each AE reviews provider qualification information using ODP standardized procedures. If an AE does not qualify a provider using ODP standardized procedures, the AE is expected to contact the provider and collect all missing documents within 30 days. If the documentation obtained does not corroborate that the provider meets qualification standards, the AE documents in HCSIS that the provider does not meet qualification standards and the provider will be prohibited from receiving payments for waiver services. ODP provides training to the AE on the correct application of the provider qualification process. ODP will enhance its monitoring of the AE and if the problem persists, initiate AE sanctions as specified in the AE Operating Agreement.

Providers are qualified by the AE where they provide the most services. As a result, the number of AEs that are counted for this measure changes on an annual basis. During the current waiver cycle, significant improvements were made to standardize the qualification process and offer training for providers. It is apparent that the qualification process is being followed by all AEs with improvement demonstrated over time. In all instances of non-compliance, remediation occurred when AEs produced documentation necessary to support provider qualifications.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure AA.a.i.7 has been met.

Table 1.8 Performance Measure AA.a.i.8.

Performance Measure: Number and percent of AEs that monitor providers using the monitoring processes developed by ODP. (Data Source:AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of AEs that monitor providers using the monitoring processes developed by ODP.* ***Denominator =*** *Number of AEs reviewed.*	N	41	39	41
	D	46	43	44
	% (N/D)	89%	91%	93%
REMEDIATION DATA				
	Noncompliant	5	4	3
Remediated by AEs locating evidence that documents their monitoring of all waiver providers		2	1	2
Remediated by AEs ensuring retraining of staff regarding Provider Monitoring requirements		1	2	1
Remediated by AEs communicating notification of results to provider in writing		2	1	0
Remediated within 30 days		4	1	1
Remediated within 31-60 days		0	3	1
Remediated within 61-90 days		1	0	1
	# Remediated	5	4	3
	% Remediated	100%	100%	100%

<u>Details</u>: On an annual basis, ODP identifies providers that are scheduled to be monitored using the ODP standardized monitoring process and tools. Upon completion of monitoring for each provider within its jurisdiction, an AE will complete and submit a standardized monitoring tool to ODP. Through the AEOMP, ODP reviews a sample of providers monitored by each AE. If an AE does not complete provider monitoring using the monitoring processes developed by ODP, the AE will remediate identified deficiencies and notify ODP of the completion of remediation actions within 30 days. Providers are monitored on a two-year cycle. As a result, the number of AEs that are counted in this measure changes on an annual basis.

VI. State Provides Financial Accountability for the Waiver

The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.
Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74~ SMM 2500; SMM 4442.8; SMM 4442.10

The state substantially meets the assurance.

Subassurance a: The State provides evidence that financial oversight exists to assure that claims are coded and paid for in accordance with reimbursement methodology specified in the approved waiver.

Table 6.1 Performance Measure FA.a.i.1.

Performance Measure: Number and percent of claims paid using correct reimbursement rates. (Data Source: PROMIS*e™)*		**SFY 12-**	**SFY 13-**	**SFY 14-**
DISCOVERY DATA				
Numerator (N) = *Number of claims paid using correct reimbursement rates.* ***Denominator =*** *Number of claims paid.*	N	6,661,108	7,312,508	7,749,380
	D	6,661,108	7,312,508	7,749,380
	% (N/D)	100%	100%	100%

Table 6.2 Performance Measure FA.a.i.2.

Performance Measure: Number and percent of claims paid for participants who were eligible on the date the service was provided. (Data Source: PROMIS*e™)*		**SFY 12-**	**SFY 13-**	**SFY 14-**
DISCOVERY DATA				
Numerator (N) = *Number of claims paid for participants who were eligible on the date the service was provided.* ***Denominator =*** *Number of claims paid.*	N	6,661,108	7,312,508	7,749,380
	D	6,661,108	7,312,508	7,749,380
	% (N/D)	100%	100%	100%

Table 6.3 Performance Measure FA.a.i.3.

Performance Measure: Number and percent of claims paid where services were consistent with those in service plans. (Data Source: PROMIS*e™)*		**SFY 12-**	**SFY 13-**	**SFY 14-**
DISCOVERY DATA				
Numerator (N) = *Number of claims paid where services were consistent with those in service plans.* ***Denominator =*** *Number of claims paid.*	N	6,661,108	7,312,508	7,749,380
	D	6,661,108	7,312,508	7,749,380
	% (N/D)	100%	100%	100%

Details: The reimbursement logic built into Pennsylvania's Medicaid Management Information System (MMIS) ensures that providers are not paid more than the rate that is stored in the system, that Waiver participants were eligible for services on the date the service was provided, and that services paid are authorized in the Waiver participant's approved ISP. A problem may be identified by a provider or providers, contractors, AE, ODP staff, or OMAP. The ODP Claims Resolution Section conducts research to identify if (a) the reimbursement rate was incorrect; (b) the eligibility information was incorrect, or (c) services paid are inconsistent with the services authorized in the ISP. If a problem is validated, appropriate corrective action is identified promptly. Systemic errors are corrected in collaboration with the MMIS contractor and, if necessary, with the contractor who supports HCSIS. Rates or eligibility information entered into the system incorrectly are corrected and the universe of paid claims that was processed using the incorrect information is identified. In the rare event that an overpayment is made, ODP will immediately notify the provider and credit any overpayment on the next PROMISe billing cycle. Thus the FMAP amount charged via the MMIS system to CMS is rapidly corrected, generally within one month or less after an overpayment is discovered. If an underpayment is made, the provider is contacted to void

and resubmit in order to obtain the increased rate.

Table 6.4 Performance Measure FA.a.i.4.

Performance Measure: Number and percent of providers whose claims are supported by documentation that services were delivered. (Data Source: Provider Monitoring)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of providers whose claims are supported by documentation that services were delivered.* ***Denominator =*** *Number of providers reviewed.*	N	195	218	246
	D	237	269	301
	% (N/D)	81%	81%	82%
REMEDIATION DATA				
	Noncompliant	42	51	55
Missing documentation was located		5	7	4
Remittance of corrected billing		21	35	48
Staff Training		5	4	1
Revision of policy/procedures		3	3	1
Termination of Provider Agreement		2	0	0
Billing suspended pending investigation of fraud by Attorney General		1	0	0
Referral to BPI		1	0	0
Provider withdrew		2	2	1
Within 30 days		24	32	31
Within 60 days		5	11	13
Within 90 days		6	6	6
Beyond 90 days		7	2	5
	# Remediated	42	51	55
	% Remediated	100%	100%	100%

Details: In addition to the set of comprehensive edits and audits incorporated into the State's CMS certified Medicaid Management Information System (MMIS), PROMISe™, ODP has outlined a Provider Monitoring process which includes On-Site Review of providers by AEs. AEs review 50% of providers annually so that over a two-year cycle, 100% of providers are reviewed on-site. The monitoring tool contains a question in reference to documentation to support claims for services. A single instance of noncompliance results in a "finding". If a provider did not have authorized services during the prior fiscal year, the provider would not have paid claims for that year and would not have claims to review. Therefore, the question regarding documentation to support claims for services is not applicable.

Agency Follow up and Improvement: ODP has focused efforts on refining the monitoring process and clarifying claim documentation expectations to stakeholders which includes a Progress Note template which has been approved for use as a resource document. ODP has communicated via Informational Packet #035-14, issued 6/13/14 "Waiver Service Claim Documentation and Remediation Process" which addresses actions that should be taken when issues arise with Waiver claims submission or supporting documentation. This communication also describes the process

to follow if the reviewer is concerned that the findings during an on-site review may be the result of fraud. This includes referrals to the Bureau of Program Integrity.

ODP has communicated via Informational Packet #062-15, issued 7/31/15, “Enforcement Actions against Noncompliant ODP Intellectual Disability Waiver Providers” what sanctions may be taken based on ODP's authority in the 55 Pa. Code Chapter 51 regulations and has established a sanction policy to articulate the actions that could be taken in the event of repeat non-compliance. These actions include withholding, disallowing, suspending or recouping payment or future payment, disallowance of new service locations, services or new individuals.

CMS Findings and Recommendations

Evidence provided by the state demonstrates that the assurance has been met. Documentation submitted by Commonwealth of Pennsylvania indicates appropriate systems in place to ensure that there is an adequate system for assuring financial accountability.