Proposed Amendment to the Adult Autism Waiver

Tentative Effective Date: January 1, 2020

KEY - Bold = Recommended additions

Strikethrough = Recommended removal

Waiver Section	Current Language	Recommended Revised Language	Reason for Change
Amendment			
2. Purpose(s) of Amendment	**In Appendix A, Role of Local/Regional Non-State Entities has been changed from Not Applicable to Applicable to include Local/Regional non-state public agencies and Local/Regional non-governmental non-state entities. Language to specify the nature of these agencies has been added. Items A-5, A-6 and A-7 have been revised as well.** **In Appendix B, Reserved Capacity was added to serve 15 participants in waiver years (WYs) 4 and 5 who need to be re-enrolled in the Adult Autism Waiver (AAW) after a stay in a hospital or rehabilitative care for more than 30 days.** **In Appendix B, the number of unduplicated participants and maximum number of participants served is being updated to reflect current allowable waiver capacity.** **Also in Appendix B, Selection of Entrants to the Waiver, Priority 2 status is removed and the Intake Process is revised and Interest List Procedure is revised to change the Interest List to a Wait List. Change in Priority status has been removed.** **In Appendix C, a new service, non-medical Transportation, is being added.** **Also in Appendix C, validation of provider qualifications for all services is being changed from every 30 months to every 36 months to align with a revised quality management strategy.** **In Appendix C, the definitions of Day Habilitation and Residential Habilitation were revised to clarify where new facilities can be located.** **In Appendix C, provider qualifications for all employment services are revised and clarification is added as to when employment services can be accessed without a referral to OVR.** **In Appendix C, language was updated to reflect that family members can provide Transportation-Trip through an OHCDS.** **In Appendix C, the educational qualifications for staff providing Career Planning were revised based on public comment.** **Appendix I is revised to include a more detailed description of the rate setting methodology.** **Revisions were made based on the new Chapter 6100 regulations, as applicable.** **Changes were made to performance measures.** **ODP changed all references to Family Living to Life Sharing.** **ODP changed all references to Supports Coordination Agencies to Supports Coordination Organizations.** **ODP changed the name of Transitional Work Service to Small Group Employment.** **ODP changed references to the Bureau of Autism Services (BAS) to the Bureau of Supports for Autism and Special Populations (BSASP) or the Office of Developmental Programs (ODP), as applicable.**		

Changes to all sections, as applicable			
	Family Living Supports Coordination Agency Supports Coordination Agencies Chapter 51 regulations Transitional Work Services Bureau of Autism Services (BAS)	~~Family Living~~ **Life Sharing** Supports Coordination ~~Agency~~ **Organization** Supports Coordination ~~Agencies~~ **Organizations** Chapter ~~51~~ **6100** regulations ~~Transitional Work Services~~ **Small Group Employment** ~~Bureau of Autism Services (BAS)~~ **Office of Developmental Programs (ODP)**	This language was updated to align with ODP's Intellectual Disability/Autism (ID/A) waivers.
Appendix A			
A-4	**Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (Select One): X **Not applicable** **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies: **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency. Specify the nature of these agencies and complete items A-5 and A-6: **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). Specify the nature of these entities and complete items A-5 and A-6:	Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (Select One): ~~X~~ Not applicable **X** Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies: **X** Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency. Specify the nature of these agencies and complete items A-5 and A-6: **The Office of Developmental Programs (ODP) has an agreement with County Mental Health/Intellectual Disability (MH/ID) programs under the control of local elected officials to perform delegated waiver and operational administrative functions. The 55 Pa. Code Chapter 6100 regulations or its regulatory successor authorize Department Designees, Administrative Entities (AEs), to perform waiver administrative functions. Each of these public agencies are delegated functions through an AE Operating Agreement. The AE implements these responsibilities and meets the requirements specified in the AE Operating Agreement. AEs perform the following delegated waiver administration function as of January 1, 2020:**	The language was updated to require AEs to conduct level of care determinations for individuals.

		Level of care (LOC) determination – Compile necessary documentation for an LOC determination, review documentation and make a determination regarding whether the applicant/participant meets LOC criteria. **ODP retains the authority for all administrative decisions and the oversight of Local/Regional non-state public entities that conduct waiver operational and administrative functions. ODP retains the authority over the administration of the Adult Autism Waiver (AAW), including the development of waiver related policies, rules, and regulations. Regulations, waiver policies, rules and guidelines are distributed by ODP through bulletins and other communications issued electronically.** **X** Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). Specify the nature of these entities and complete items A-5 and A-6: **When a County MH/ID program is unwilling or unable to perform AE functions, ODP will select a non-governmental entity to perform delegated functions. ODP may select a multi-county MH/ID program or non-profit entity. The 55 Pa. Code Chapter 6100 regulations or its regulatory successor authorize Department Designees, AEs, to perform waiver administrative functions. These public agencies are delegated functions through an AE Operating Agreement. The AE implements these responsibilities and meets the requirements specified in the AE Operating Agreement. A non-governmental entity designated as an AE is delegated the same operational and administrative functions delegated to public agencies. ODP also retains the authority for all administrative decisions and the oversight of non-governmental entities that conduct waiver operational and administrative functions. ODP retains authority over the administration of the AAW, including the development of waiver related policies, rules, and regulations.**	

		Regulations, waiver policies, rules and guidelines are distributed by ODP through bulletins and other communications issued electronically.	
A-5	**Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities**. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions: Bureau of Autism Services	Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions: ~~Bureau of Autism Services~~ **ODP is responsible for assessing the performance of functions delegated to public agencies and non-governmental entities designated as AEs.**	ODP added language regarding its oversight of AE functions.
A-6	**Assessment Methods and Frequency**. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed: BAS staff review documentation of all denials of functional eligibility before the applicant is notified of a denial. BAS staff also review all approvals of functional eligibility where the applicant has substantial functional limitations in only three of the six major life activities specified in Appendix B-1-b before the applicant is notified of approval or denial. In addition, BAS staff review 20% of other functional eligibility determinations that results in an approval (every fifth assessment by each contracted assessor) on an ongoing basis. BAS staff can either require new information or override the determination by the functional eligibility assessment contractor. Within 2 business days of receiving the assessment, the BAS staff determines if it requires clinical review. Clinical review is required if the applicant's functional limitations are at or below 3 out of 6 areas of major life activity. Clinical then has a total of 5 days to determine if the applicant meets the AAW functional eligibility requirement or not, which includes obtaining new information to determine eligibility if necessary.	Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed: ~~BAS staff review documentation of all denials of functional eligibility before the applicant is notified of a denial. BAS staff also review all approvals of functional eligibility where the applicant has substantial functional limitations in only three of the six major life activities specified in Appendix B-1-b before the applicant is notified of approval or denial. In addition, BAS staff review 20% of other functional eligibility determinations that results in an approval (every fifth assessment by each contracted assessor) on an ongoing basis. BAS staff can either require new information or override the determination by the functional eligibility assessment contractor.~~ ~~Within 2 business days of receiving the assessment, the BAS staff determines if it requires clinical review. Clinical review is required if the applicant's functional limitations are at or below 3 out of 6 areas of major life activity. Clinical then has a total of 5 days to determine if the applicant meets the AAW functional eligibility requirement or not, which includes obtaining new information to determine eligibility if necessary.~~	ODP added details regarding the method of ODP oversight of the AE.

		ODP monitors AEs on a three-year cycle to assess compliance with the AE Operating Agreements using a standard ODP Oversight Process review tool. ODP gathers AE performance data annually via a self-assessment of performance of delegated functions. The self-assessment for one-third of the AEs is reviewed and validated by ODP via an on-site review to substantiate compliance during one year of each three year cycle. During this on-site review, ODP verifies that all necessary documentation for an LOC determination is completed in accordance with the AE Operating Agreement.	
Appendix A: Quality Improvement: Administrative Authority of the Single State Medicaid Agency			
A-a.i	**Performance Measures** (Language purposely omitted. Please see approved Adult Autism Waiver for full language.) **Performance Measure AA1: Number and percent of functional eligibility (FE) determinations conducted by contracted entities consistent with waiver requirements.** **Numerator = Number of FE determinations conducted by contracted entities consistent with waiver requirements. Denominator = Number of FE determinations conducted by contracted entities**. **Data Source** (Select one): **Other** If 'Other' is selected, specify: **BAS's Participant Tracking Database** **Performance Measure AA2: Number and percent of waiver amendments, renewals and notices in the PA Bulletin reviewed and approved by the State Medicaid Director.** **Numerator = Number of waiver amendments, renewals and notices in the PA Bulletin reviewed and approved by the State Medicaid Director. Denominator = Number of waiver amendments, renewals and notices in the PA Bulletin.** **Data Source** (Select one): **Other**	Performance Measures ~~Performance Measure AA1: Number and percent of functional eligibility (FE) determinations conducted by contracted entities consistent with waiver requirements.~~ ~~Numerator = Number of FE determinations conducted by contracted entities consistent with waiver requirements. Denominator = Number of FE determinations conducted by contracted entities.~~ ~~Data Source (Select one):~~ ~~Other~~ ~~If 'Other' is selected, specify:~~ ~~BAS's Participant Tracking Database~~ Performance Measure ~~AA2~~ **AA1**: Number and percent of waiver amendments, renewals and notices in the PA Bulletin reviewed and approved by the State Medicaid Director. Numerator = Number of waiver amendments, renewals and notices in the PA Bulletin reviewed and approved by the State Medicaid Director. Denominator = Number of waiver amendments, renewals and notices in the PA Bulletin. Data Source (Select one): Other If 'Other' is selected, specify: Adult Autism Waiver PA Bulletin Tracking Spreadsheet	Functional eligibility determinations will no longer be conducted and therefore ODP will no longer track this performance measure.

	If 'Other' is selected, specify: **Adult Autism Waiver PA Bulletin Tracking Spreadsheet** **Performance Measure AA3: Number and percent of providers with signed Medical Assistance Provider Agreements and AAW Supplemental Agreements. Numerator = Number of providers with signed Medical Assistance Provider Agreements and AAW Supplemental Agreements. Denominator = Number of providers.** **Data Source** (Select one): **Other** If 'Other' is selected, specify: **BAS's Provider Enrollment Database** **Performance Measure AA4: Number and percent of participants distributed by region utilizing the geographic distribution criteria identified in Appendix B-3 of the waiver. Numerator = Number of participants distributed by region utilizing the geographic distribution criteria identified in Appendix B-3 of the waiver. Denominator = Number of participants.** **Data Source** (Select one): **Other** If 'Other' is selected, specify: **BAS's Participant Tracking Database** **Frequency of data collection/generation** *(check each that applies):* Continuously and Ongoing	Performance Measure ~~AA3~~ **AA2**: Number and percent of providers with signed Medical Assistance Provider Agreements and ~~AAW Supplemental~~ **ODP Provider** Agreements. Numerator = Number of providers with signed Medical Assistance Provider Agreements and ~~AAW Supplemental~~ **ODP Provider** Agreements. Denominator = Number of providers. Data Source (Select one): Other If 'Other' is selected, specify: BAS's Provider Enrollment Database Performance Measure ~~AA4~~ **AA3**: Number and percent of ~~participants distributed by region utilizing the geographic distribution criteria identified in Appendix B-3 of the waiver. Numerator = Number of participants distributed by region utilizing the geographic distribution criteria identified in Appendix B-3 of the waiver. Denominator = Number of participants.~~ **waiver openings distributed equitably across all geographic areas covered by the waiver using criteria identified in Appendix B-3. Numerator = number of waiver openings distributed equitably across all geographic areas covered by the waiver using criteria identified in Appendix B-3. Denominator = number of waiver openings distributed.** Data Source (Select one): Other If 'Other' is selected, specify: BAS's Participant Tracking Database **Frequency of data collection/generation** *(check each that applies):* ~~Continuously and Ongoing~~ **X Annually**	Changes were made to align with CMS guidance on AA performance measures to focus on equitable distribution of waiver openings in all geographic areas covered by the waiver.
A-a.ii	If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. To verify the accuracy of functional eligibility dates used for the performance measure in a.i.a., BAS reviews paper records for a sample of functional	If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. ~~To verify the accuracy of functional eligibility dates used for the performance measure in a.i.a., BAS reviews paper records for a sample of functional~~	Functional eligibility determinations will no longer be conducted and therefore this

	eligibility determinations. Since BAS staff conduct some determinations as identified in Appendix B-6-a, a BAS staff person may not review his or her own determination. The sample is sufficient to obtain a 90% confidence level with a 10% margin of error. For each assessment reviewed, BAS compares the date of assessment in the Participant Tracking Database to the date listed on the paper record. BAS also checks the individual's application to ensure the Participant Tracking Database is accurate regarding the date the application was received. Finally, BAS staff review data regarding functional eligibility assessments to identify if any assessors are outliers in approval or denial of functional eligibility, and observe interviews for any assessors that are outliers to review their application of functional eligibility criteria.	~~eligibility determinations. Since BAS staff conduct some determinations as identified in Appendix B-6-a, a BAS staff person may not review his or her own determination. The sample is sufficient to obtain a 90% confidence level with a 10% margin of error. For each assessment reviewed, BAS compares the date of assessment in the Participant Tracking Database to the date listed on the paper record. BAS also checks the individual's application to ensure the Participant Tracking Database is accurate regarding the date the application was received. Finally, BAS staff review data regarding functional eligibility assessments to identify if any assessors are outliers in approval or denial of functional eligibility, and observe interviews for any assessors that are outliers to review their application of functional eligibility criteria.~~	language is being removed.
A-b	**Methods for Remediation/Fixing Individual Problems** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. Each quarter, BAS reviews information collected from the discovery activities during that quarter. BAS staff meet quarterly to discuss findings and identify remediation strategies if necessary. If there are multiple issues of performance, the BAS Director or designee will set priorities regarding which issue to address first. If the information indicates that there are issues of non-compliance with the waiver requirements for functional eligibility determinations, BAS will first assess whether the problems are system-wide or isolated to a particular contractor or region. If problems are system-wide, the BAS Director or a designee will meet with individuals involved in the administrative function. For example, if functional eligibility determinations are not timely completed on a systemic basis, BAS staff who make functional eligibility determinations would meet with contracted individuals who perform functional eligibility determinations. During the meeting systemic issues that lead to untimely performance or instances where BAS overrides the assessor's decision would be identified and	Methods for Remediation/Fixing Individual Problems Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. ~~Each quarter, BAS reviews information collected from the discovery activities during that quarter. BAS staff meet quarterly to discuss findings and identify remediation strategies if necessary. If there are multiple issues of performance, the BAS Director or designee will set priorities regarding which issue to address first.~~ ~~If the information indicates that there are issues of non-compliance with the waiver requirements for functional eligibility determinations, BAS will first assess whether the problems are system-wide or isolated to a particular contractor or region.~~ ~~If problems are system-wide, the BAS Director or a designee will meet with individuals involved in the administrative function. For example, if functional eligibility determinations are not timely completed on a systemic basis, BAS staff who make functional eligibility determinations would meet with contracted individuals who perform functional eligibility determinations. During the meeting systemic issues that lead to untimely performance or instances where BAS overrides the assessor's decision would be identified and~~	This language was updated to align with the ID/A waivers.

	possible solutions such as training, technical assistance, more intensive monitoring, or process changes would be discussed. The BAS Director or designee will then develop a performance improvement project to address the issue. If performance issues are isolated to only one region, contractor, or provider, the BAS Director or designee will communicate with the responsible DHS staff, contractor, or provider to identify the reason for the issues with performance. In addition, BAS may interview participants, family members, and providers, and/or review additional records, as necessary. The BAS Director or designee will determine corrective action based on the data collected and the previous performance of the staff person or provider. Examples of corrective action include additional training, more intensive monitoring by BAS, follow-up and resolution through a corrective action plan. For performance issues with contractors, BAS will follow DHS departmental policy regarding sanctions and, if warranted, termination of the contract.	~~possible solutions such as training, technical assistance, more intensive monitoring, or process changes would be discussed. The BAS Director or designee will then develop a performance improvement project to address the issue.~~ ~~If performance issues are isolated to only one region, contractor, or provider, the BAS Director or designee will communicate with the responsible DHS staff, contractor, or provider to identify the reason for the issues with performance. In addition, BAS may interview participants, family members, and providers, and/or review additional records, as necessary. The BAS Director or designee will determine corrective action based on the data collected and the previous performance of the staff person or provider. Examples of corrective action include additional training, more intensive monitoring by BAS, follow-up and resolution through a corrective action plan. For performance issues with contractors, BAS will follow DHS departmental policy regarding sanctions and, if warranted, termination of the contract~~ **AA3. Number and percent of waiver openings distributed equitably across all geographic areas covered by the waiver using criteria identified in Appendix B-3. If it is discovered that an error in calculation was made, the distribution will be revised accordingly to reflect the correct calculation.**	
APPENDIX B			
B-1-b	**Additional Criteria.** The State further specifies its target group(s) as follows: Waiver eligibility is limited to people who: • Meet Medical Assistance Program clinical and financial eligibility for Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) services, and • Have a diagnosis of Autism Spectrum Disorder (ASD) before the age of 22 as determined by a licensed psychologist, licensed physician, licensed physician assistant, or certified registered nurse practitioner using the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) applicable at the time of the diagnosis, and	Additional Criteria. The State further specifies its target group(s) as follows: Waiver eligibility is limited to people who: • Meet Medical Assistance Program clinical and financial eligibility for Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/~~I~~ID) services, and • Have a diagnosis of Autism Spectrum Disorder (ASD) **manifested** before the age of 22 as determined by a licensed psychologist, **certified school psychologist, psychiatrist, developmental pediatrician,** licensed physician, licensed physician assistant, or certified registered nurse practitioner using the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) applicable at the time of the diagnosis, and	This language was updated to align with the ID/A waivers.

	• Have substantial functional limitations in three or more major life activities as a result of ASDs and/or other developmental disabilities that are likely to continue indefinitely: self-care, receptive and expressive language, learning, mobility, self direction and/or capacity for independent living, and • Are 21 years of age or older	• Have substantial functional limitations in three or more major life activities as a result of ASDs and/or other developmental disabilities that are likely to continue indefinitely: self-care, receptive and expressive language, learning, mobility, self-direction and/or capacity for independent living, and • Are 21 years of age or older**, and** • **Are residents of Pennsylvania.**	ODP is adding Pennsylvania residency to waiver eligibility criteria.
B-3-a	**Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J: Year 1 – 702 Year 2 – 702 Year 3 – 702 Year 4 – 702 Year 5 – 702	Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J: Year 1 – 702 Year 2 – 702 Year 3 – ~~702~~ **754** Year 4 – ~~702~~ **754** Year 5 – ~~702~~ **754**	ODP updated the unduplicated numbers to reflect the maximum number of participants served.
B-3-b	The limit that applies to each year of the waiver period is specified in the following table: Year 1 – 668 Year 2 – 668 Year 3 – 668 Year 4 – 668 Year 5 – 668	The limit that applies to each year of the waiver period is specified in the following table: Year 1 – 668 Year 2 – 668 Year 3 – ~~668~~ **718** Year 4 – ~~668~~ **718** Year 5 – ~~668~~ **718**	ODP updated the maximum number of participants served to reflect the current allowable waiver capacity.
B-3-c	**Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:	Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:	ODP added Reserved Capacity to be able to re-enroll participants who need to be disenrolled due to

<table>
<tr>
<td></td>
<td>Not applicable. The state does not reserve capacity.
X The State reserves capacity for the following purpose(s).

Purpose(s) the State reserves capacity for:
People transferring from the Adult Community Autism Program
People discharged from a state hospital
People identified in Adult Protective Services investigations

Purpose (provide a title or short description to use for lookup):
Purpose (describe):
Describe how the amount of reserved capacity was determined:

The capacity that the State reserves in each waiver year is specified in the following table:</td>
<td>Not applicable. The state does not reserve capacity.
X The State reserves capacity for the following purpose(s).

Purpose(s) the State reserves capacity for:
People transferring from the Adult Community Autism Program
People discharged from a state hospital
People identified in Adult Protective Services investigations
Hospital/Rehabilitation Care

Purpose (provide a title or short description to use for lookup):
Hospital/Rehabilitation Care

Purpose (describe):
ODP reserves waiver capacity for participants requiring hospital/rehabilitation care beyond 30 consecutive days and up to 6 consecutive months from the first date of leave. Settings which are considered hospital/rehabilitation care include medical and psychiatric hospital settings, rehabilitation care programs and nursing homes. Settings which are not considered hospital/rehabilitation care include residential treatment facilities, state mental health hospitals, approved private schools and private and state ICFs/ID.

Describe how the amount of reserved capacity was determined:
The amount of reserved capacity is determined by the historical average number of participants who have been on hospital/rehabilitation leave for more than 30 consecutive days and up to 6 consecutive months.

The capacity that the State reserves in each waiver year is specified in the following table:

<table>
<tr><th>Waiver Year</th><th>Capacity Reserved</th></tr>
<tr><td>Year 1</td><td>0</td></tr>
<tr><td>Year 2</td><td>0</td></tr>
<tr><td>Year 3</td><td>0</td></tr>
<tr><td>Year 4</td><td>15</td></tr>
<tr><td>Year 5</td><td>15</td></tr>
</table>
</td>
<td>hospitalization/ rehabilitative care beyond 30 days.</td>
</tr>
</table>

B-3-f	**Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver: Prioritization Criteria BAS prioritizes entry into the waiver based on four criteria: use of long-term support services; geographic distribution of capacity; a lottery that was held to help determine the order of application for requests for service during the first six weeks of the waiver; and the date and time of requests for service received after the first six weeks of the waiver. - Use of Long-Term Support Services Since the intent of the Adult Autism Waiver is to serve new individuals, BAS prioritizes entry as follows: Priority 1. People not receiving ongoing state funded or state and Federally funded long-term support services (e.g., Medicaid HCBS Waiver supports; ICF/ID; nursing facility; services in a state hospital; Community Residential Rehabilitation Services; services in a Long-Term Structured Residence; Residential Treatment Facility; and extended acute care for people with serious mental illness). -Priority 2. If waiver capacity remains, the waiver will serve people who do not meet Priority 1 criteria. Priority 2 individuals will only receive applications if waiver capacity remains available after all Priority 1 individuals across the Commonwealth have had their applications processed. - Geographic Distribution Within each priority group, BAS allocates waiver capacity on a regional basis to ensure access across the Commonwealth. Four regions are defined as follows: West: Allegheny, Armstrong, Beaver, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Venango, Warren, Washington, and Westmoreland Counties	Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver: ~~Prioritization Criteria~~ **Prioritization of entry into the waiver using the below criteria will apply to individuals who meet eligibility requirements from the current priority 1 interest list prior, and up to, December 31, 2019**. **Enrollment priority is given to those who requested service prior to January 1, 2020 using** ~~BAS prioritizes entry into the waiver based on four~~ **three** criteria: use of long-term support services; geographic distribution of capacity;~~ a lottery that was held to help determine the order of application for requests for service during the first six weeks of the waiver;~~ and the date and time of request~~s~~ for service.~~ received after the first six weeks of the waiver~~ **Individuals currently on the priority 1 interest list, who have requested services prior to January 1, 2020, have had an initial LOC evaluation completed, and meet LOC requirements will be placed on a waiting list until capacity is available. When waiver capacity becomes available, they will receive an application based on the prioritization criteria listed below.** **After the priority 1 waiting list is exhausted, priority will be based on urgency of need as determined by the Prioritization of Urgency of Needs (PUNS) assessment or its successor.** **Prioritization Criteria** - Use of Long-Term Support Services ~~Since the intent of the Adult Autism Waiver is to serve new individuals, BAS~~ **ODP** prioritizes entry ~~as follows: Priority 1.~~ **to** ~~P~~**p**eople not receiving ongoing state funded or state and Federally funded long-term support services (e.g., Medicaid HCBS Waiver supports; ICF/ID; nursing facility; services in a state hospital; Community Residential Rehabilitation Services; services in a Long-Term Structured Residence; Residential Treatment Facility; and extended acute care for people with serious mental illness). ~~Priority 2. If waiver capacity remains, the waiver will serve people who do not meet Priority 1 criteria. Priority 2 individuals will only receive applications if~~	Changes were made to reflect the transition from use of an interest list to a waiting list for individuals previously in priority 1 and removal of priority 2 category. ODP deleted language related to the lottery, which is no longer applicable. ODP also deleted language relating to being placed on the interest list, because individuals cannot be placed on this list after 9/30/19. ODP added language explaining that after exhaustion of the current interest list, priority will be based on urgency of need.

	Central: Adams, Bedford, Blair, Cambria, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Huntington, Juniata, Lancaster, Lebanon, Lycoming, Mifflin, Montour, Northumberland, Perry, Snyder, Somerset, Union, and York Counties Southeast: Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties Northeast: Berks, Bradford, Carbon, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming Counties When BAS adds new capacity, it will add capacity to each region so that the total waiver capacity is allocated in proportion to Pennsylvania's population age 21 or older in each region, according to the most recent version of the U.S. Census Bureau's Current Population Estimates. Once enrolled, participants may move anywhere in the Commonwealth and continue to be enrolled in the waiver. -Lottery for Requests for Service during the First Six Weeks When the waiver began on July 1, 2008, the Commonwealth collected requests for services for a six-week period using the Intake Process described below. Then BAS randomly assigned a number to each Priority 1 individual for whom services were requested during the six-week period. Applications have been sent to all Priority 1 individuals who received a randomly assigned number. There are no Priority 1 individuals on the interest list for the Adult Autism Waiver from the initial six-week period. BAS also randomly assigned a number to each Priority 2 individual for whom services were requested during the six week period. Priority 2 individuals who received a randomly assigned number remain on the interest list for the Adult Autism Waiver. -Date and Time of Requests for Service Received After the Initial Six-Week Period	~~waiver capacity remains available after all Priority 1 individuals across the Commonwealth have had their applications processed.~~ - Geographic Distribution ~~Within each priority group,~~ ~~BAS~~ **ODP** allocates waiver capacity on a regional basis to ensure access across the Commonwealth. Four regions are defined as follows: West: Allegheny, Armstrong, Beaver, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Venango, Warren, Washington, and Westmoreland Counties Central: Adams, Bedford, Blair, Cambria, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Huntington, Juniata, Lancaster, Lebanon, Lycoming, Mifflin, Montour, Northumberland, Perry, Snyder, Somerset, Union, and York Counties Southeast: Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties Northeast: Berks, Bradford, Carbon, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming Counties When ~~BAS~~ **ODP** adds new capacity, it will add capacity to each region so that the total waiver capacity is allocated in proportion to Pennsylvania's population age 21 or older in each region, according to the most recent version of the U.S. Census Bureau's Current Population Estimates. Once enrolled, participants may move anywhere in the Commonwealth and continue to be enrolled in the waiver. ~~-Lottery for Requests for Service during the First Six Weeks~~ ~~When the waiver began on July 1, 2008, the Commonwealth collected requests for services for a six-week period using the Intake Process described below. Then BAS randomly assigned a number to each Priority 1 individual for whom services were requested during the six-week period. Applications have~~	

	The Intake Process described below continues to be used. Within each priority group and region, BAS sends applications in chronological order based on the date and time BAS received a request for services. Intake Process Individuals can request services by calling the BAS publicized, toll-free telephone number and leaving a message; by completing the Information and Referral Tool (IRT) that is available on-line; or by requesting to be contacted through an on-line site called COMPASS. The IRT website and COMPASS will also include the toll-free telephone number. The IRT and COMPASS will allow the person to enter their name and contact information into a form. When a person completes the form, the person's name and contact information will be emailed to BAS staff with a date and time stamp. If the person chooses to leave a message on the toll-free telephone number, the voice message system will also record the date and time stamp of the call. This date and time stamp will be used to determine the order in which the person is listed on the interest list. Using the information obtained through the telephone contact, the IRT, or COMPASS, BAS checks the Department's management information systems to identify whether the person is currently receiving on-going long-term support services in order to establish whether the person is a Priority 1 or Priority 2 individual. BAS also contacts the person's County Mental Health Agency to identify whether the person is currently receiving services in a Community Residential Rehabilitation Services; services in a Long-Term Structured Residence; Residential Treatment Facility; or extended acute care for people with serious mental illness BAS returns each contact request to verify the person's (and, if applicable, representative's) contact information. BAS prioritizes requests for services based on the criteria described in the Prioritization Criteria section above. When waiver capacity is available to a person and the person is over the age of 21, BAS will send the person and representative (if applicable) an application. If waiver capacity is available and the person's age is between 18 and 21 years	~~been sent to all Priority 1 individuals who received a randomly assigned number. There are no Priority 1 individuals on the interest list for the Adult Autism Waiver from the initial six-week period.~~ ~~BAS also randomly assigned a number to each Priority 2 individual for whom services were requested during the six week period. Priority 2 individuals who received a randomly assigned number remain on the interest list for the Adult Autism Waiver.~~ ~~Date and Time of Requests for Service Received After the Initial Six-Week Period~~ ~~The Intake Process described below continues to be used. Within each priority group and region, BAS sends applications in chronological order based on the date and time BAS received a request for services.~~ Intake Process ~~Individuals can request services by calling the BAS publicized, toll-free telephone number and leaving a message; by completing the Information and Referral Tool (IRT) that is available on-line; or by requesting to be contacted through an on-line site called COMPASS. The IRT website and COMPASS will also include the toll-free telephone number. The IRT and COMPASS will allow the person to enter their name and contact information into a form. When a person completes the form, the person's name and contact information will be emailed to BAS staff with a date and time stamp. If the person chooses to leave a message on the toll-free telephone number, the voice message system will also record the date and time stamp of the call. This date and time stamp will be used to determine the order in which the person is listed on the interest list.~~ ~~Using the information obtained through the telephone contact, the IRT, or COMPASS, BAS checks the Department's management information systems to identify whether the person is currently receiving on-going long-term support services in order to establish whether the person is a Priority 1 or Priority 2 individual. BAS also contacts the person's County Mental Health Agency to~~	

	of age, BAS will wait until the person turns 21 years of age and waiver capacity is again available to send the person and representative (if applicable) an application. BAS assists the person or representative if necessary to complete the application and the person or representative may call BAS for assistance. When the person and/or representative returns the application, BAS staff, with assistance as necessary from the functional eligibility contractors described in Appendix A, determine whether the person meets the eligibility requirements specified in Appendix B-1. If BAS determines the person is not eligible for the waiver, BAS contacts the next person based on the criteria described in the Prioritization Criteria section above. Person identified in an Adult Protective Services (APS) investigation as needing long-term support: Referrals of individuals identified during an Adult Protective Services investigation as needing long-term supports will be made to the APS liaison, who is a BAS staff person. The APS liaison is responsible for coordinating the waiver enrollment process within BAS. People transferring from the Adult Community Autism Program (ACAP): BAS will coordinate the transfer of any individuals from ACAP to the waiver with the ACAP provider. BAS and the ACAP provider will work together to ensure that there is no interruption of services. Person ready for discharge to the community from a state hospital and in need of long-term support: BAS will consult with the Office of Mental Health and Substance Abuse Services (OMHSAS) to identify individuals who are ready for discharge from an Institution for Mental Disease and will coordinate any identified individual's enrollment in to the waiver. BAS and OMHSAS will work together to ensure that there is no interruption of services. Interest List Procedure If the waiver capacity in a region is filled, individuals requesting services will be placed on an interest list until capacity is available. If waiver capacity becomes available in a region, Priority 1 individuals on the interest list in that region will receive applications in chronological order based on the date and time BAS received a request for waiver services. If waiver capacity remains available in a	~~identify whether the person is currently receiving services in a Community Residential Rehabilitation Services; services in a Long-Term Structured Residence; Residential Treatment Facility; or extended acute care for people with serious mental illness~~ ~~BAS returns each contact request to verify the person's (and, if applicable, representative's) contact information. BAS prioritizes requests for services based on the criteria described in the Prioritization Criteria section above.~~ When waiver capacity is available to a person and the person is over the age of 21, ~~BAS~~ **ODP** will send the person and representative (if applicable) an application. If waiver capacity is available and the person's age is between 18 and 21 years of age, ~~BAS~~ **ODP** will wait until the person turns 21 years of age and waiver capacity is again available to send the person and representative (if applicable) an application. ~~BAS~~ **ODP** assists the person or representative if necessary to complete the application and the person or representative may call ~~BAS~~ **ODP** for assistance. When the person and/or representative returns the application, ~~BAS~~ **ODP** staff ~~with assistance as necessary from the functional eligibility contractors described in Appendix A~~ determine whether the person meets the eligibility requirements specified in Appendix B-1. If ~~BAS~~ **ODP** determines the person is not eligible for the waiver, ~~BAS~~ **ODP** contacts the next person based on the criteria described in the Prioritization Criteria section above. Person identified in an Adult Protective Services (APS) investigation as needing long-term support: Referrals of individuals identified during an Adult Protective Services investigation as needing long-term supports will be made to the APS liaison, who is a**n** ~~BAS~~ **ODP** staff person. The APS liaison is responsible for coordinating the waiver enrollment process within ~~BAS~~ **ODP**. People transferring from the Adult Community Autism Program (ACAP): ~~BAS~~ **ODP** will coordinate the transfer of any individuals from ACAP to the waiver with the ACAP provider. ~~BAS~~ **ODP** and the ACAP provider will work together to ensure that there is no interruption of services.	

	region after all Priority 1 requests from that region have been processed, BAS will apply the Unused Capacity Procedure. Unused Capacity Procedure If a region does not have enough Priority 1 applicants to use available waiver capacity, BAS will monitor the number of Priority 1 requests for services received in the next 90 calendar days. BAS will send applications to Priority 1 individuals who request services during this time in chronological order until the region's waiver capacity is used. If the region still has waiver capacity after 90 calendar days, BAS will reallocate unused capacity to regions where Priority 1 individuals are on an interest list. BAS will reallocate capacity to these regions in proportion to each region's population age 21 or older based on the most recently available version of the U.S. Census Bureau's Current Population Estimates. If waiver capacity remains available after all Priority 1 individuals have had their applications processed, BAS will return the remaining waiver capacity to the original region (i.e., the region that did not have enough Priority 1 individuals to use its capacity). BAS will first send applications to Priority 2 individuals in this region who requested services during the initial six-week period, in order of their randomly assigned number. If capacity remains available, BAS will send applications to Priority 2 individuals in this region who requested services after the six-week period, in chronological order. If the region still has waiver capacity after processing all requests from Priority 2 individuals in that region, BAS will reallocate unused capacity to regions where Priority 2 individuals are on an interest list. BAS first will send applications to Priority 2 individuals who requested services during the initial six-week period, in order of their randomly assigned number. BAS will then send applications to Priority 2 individuals who requested services after the six-week period, in chronological order. CHANGE IN PRIORITY STATUS If an individual changes priority status after their initial request for services, the person is reassigned to the new priority status as of the date their status changed. The person is enrolled in chronological order based on the date of	Person ready for discharge to the community from a state hospital and in need of long-term support: ~~BAS~~ **ODP** will consult with the Office of Mental Health and Substance Abuse Services (OMHSAS) to identify individuals who are ready for discharge from an Institution for Mental Disease and will coordinate any identified individual's enrollment in to the waiver. ~~BAS~~ **ODP** and OMHSAS will work together to ensure that there is no interruption of services. ~~Interest List Procedure~~ ~~If the waiver capacity in a region is filled, individuals requesting services will be placed on an interest list until capacity is available. If waiver capacity becomes available in a region, Priority 1 individuals on the interest list in that region will receive applications in chronological order based on the date and time BAS received a request for waiver services. If waiver capacity remains available in a region after all Priority 1 requests from that region have been processed, BAS will apply the Unused Capacity Procedure.~~ ~~Unused Capacity Procedure~~ ~~If a region does not have enough Priority 1 applicants to use available waiver capacity, BAS will monitor the number of Priority 1 requests for services received in the next 90 calendar days. BAS will send applications to Priority 1 individuals who request services during this time in chronological order until the region's waiver capacity is used. If the region still has waiver capacity after 90 calendar days, BAS will reallocate unused capacity to regions where Priority 1 individuals are on an interest list. BAS will reallocate capacity to these regions in proportion to each region's population age 21 or older based on the most recently available version of the U.S. Census Bureau's Current Population Estimates.~~ ~~If waiver capacity remains available after all Priority 1 individuals have had their applications processed, BAS will return the remaining waiver capacity to the original region (i.e., the region that did not have enough Priority 1 individuals to use its capacity). BAS will first send applications to Priority 2 individuals in this region who requested services during the initial six-week period, in order of their randomly assigned number. If capacity remains available, BAS will send applications to Priority 2 individuals in this region who~~	

	their change in Priority status. For example, if a Priority 2 person disenrolls from another Medicaid HCBS waiver, that person would become a Priority 1 individual. The person would receive an application with other Priority 1 individuals. The date he or she disenrolled from the other waiver would be considered the date of requested services for purposes of receiving an application. If a Priority 1 person enrolls in another waiver, that person would become a Priority 2 individual. If applications are sent to Priority 2 individuals, the person would receive an application with other Priority 2 individuals. The date he or she enrolled in the other waiver would be considered the date of requested services for purposes of receiving an application.	~~requested services after the six-week period, in chronological order. If the region still has waiver capacity after processing all requests from Priority 2 individuals in that region, BAS will reallocate unused capacity to regions where Priority 2 individuals are on an interest list. BAS first will send applications to Priority 2 individuals who requested services during the initial six-week period, in order of their randomly assigned number. BAS will then send applications to Priority 2 individuals who requested services after the six-week period, in chronological order.~~ ~~CHANGE IN PRIORITY STATUS~~ ~~If an individual changes priority status after their initial request for services, the person is reassigned to the new priority status as of the date their status changed. The person is enrolled in chronological order based on the date of their change in Priority status. For example, if a Priority 2 person disenrolls from another Medicaid HCBS waiver, that person would become a Priority 1 individual. The person would receive an application with other Priority 1 individuals. The date he or she disenrolled from the other waiver would be considered the date of requested services for purposes of receiving an application. If a Priority 1 person enrolls in another waiver, that person would become a Priority 2 individual. If applications are sent to Priority 2 individuals, the person would receive an application with other Priority 2 individuals. The date he or she enrolled in the other waiver would be considered the date of requested services for purposes of receiving an application.~~	
B-6-b	**Responsibility for Performing Evaluations and Reevaluations**. Level of care evaluations and reevaluations are performed (select one): X **Other** Specify: Level of care evaluations may be conducted by any physician licensed in Pennsylvania under PA Code Title 49, Chapter 17. If the physician indicates ICF/IID level of care, a Qualified Intellectual Disabilities Professional (QIDP) employed by ODP will evaluate whether the person meets ICF/ID level of care. If the physician indicates the person meets ICF/ORC level of care criteria, an additional assessment is not necessary.	Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (select one): X Other Specify: ~~Level of care evaluations may be conducted by any physician licensed in Pennsylvania under PA Code Title 49, Chapter 17.~~ ~~If the physician indicates ICF/IID level of care, a Qualified Intellectual Disabilities Professional (QIDP) employed by ODP will evaluate whether the person meets ICF/ID level of care. If the physician indicates the person meets ICF/ORC level of care criteria, an additional assessment is not necessary.~~ **Individuals added to the waiver waiting list as of January 1, 2020 will have**	Changes were made to identify the AE as the entity responsible for conducting initial LOC evaluations and identify the individuals who may conduct the reevaluations.

		their initial level of care assessed by Qualified Developmental Disabilities Professionals through their AE. Once enrolled in the waiver, reevaluations of level of care may be conducted by any physician, physician's assistant, or certified registered nurse practitioner licensed in the United States.	
B-6-c	**Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants: Qualified Intellectual Disabilities Professional (QIDP) must meet one of the following three criteria: 1. A Master's degree or above from an accredited college or university and one year of work experience working directly with persons with intellectual disabilities; 2. A Bachelor's degree from an accredited college or university and two year's work experience working directly with persons with intellectual disabilities; or 3. An Associate's degree or 60 credit hours from an accredited college or university and four year's work experience working directly with persons with intellectual disabilities. Physicians are not contracted with the state to perform level of care evaluations.	Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants: **The AE is responsible for having a Qualified Developmental Disability Professional (QDDP) perform the level of care evaluation.** ~~Qualified Intellectual Disabilities Professional (QI~~**D**DP~~s)~~ must meet one of the following three criteria: 1. A Master's degree or ~~above~~ **higher level of education** from an accredited college or university and one year of work experience working directly with persons with ~~intellectual~~ **developmental** disabilities; 2. A Bachelor's degree from an accredited college or university and two year's work experience working directly with persons with ~~intellectual~~ **developmental** disabilities; or 3. An Associate's degree or 60 credit hours from an accredited college or university and four year's work experience working directly with persons with ~~intellectual~~ **developmental** disabilities. ~~Physicians are not contracted with the state to perform level of care evaluations.~~ **The AE is responsible to ensure that no conflict of interest exists in the level of care evaluation process.** **AEs may contract with another agency or independent QDDP who meets the criteria above to obtain a QDDP certification of need for an ICF/ID or ICF/ORC level of care in order to ensure a conflict-free determination.**	The language was changed to add that the AE is responsible for having a Qualified Developmental Disability Professional perform the initial LOC evaluation and ensuring no conflict of interest exists in the LOC evaluation process.
B-6-d	**Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws,	Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws,	ODP revised the language to add the AEs as being responsible for

	regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized. ICF/ID criteria: The ICF/ID level of care shall be indicated only when the applicant or recipient: (1) Requires active treatment. (2) Has a diagnosis of an intellectual disability. (3) Has been recommended for an ICF/ID level of care based on a medical evaluation. A diagnosis of an intellectual disability is documented by meeting the following requirements: (1) A licensed psychologist, certified school psychologist or a licensed physician who practices psychiatry shall certify that the applicant or recipient has significantly sub-average intellectual functioning which is documented by one of the following: (i) Performance that is more than two standard deviations below the mean as measurable on a standardized general intelligence test. (ii) Performance that is slightly higher than two standard deviations below the mean of a standardized general intelligence test during a period when the person manifests serious impairments of adaptive behavior. (2) A qualified intellectual disabilities professional as defined in 42 CFR 483.430 (relating to condition of participation: facility staffing) shall certify that the applicant or recipient has impairments in adaptive behavior as provided by a standardized assessment of adaptive functioning which shows that the applicant or recipient has one of the following: (i) Significant limitations in meeting the standards of maturation, learning, personal independence or social responsibility of his age and cultural group. (ii) Substantial functional limitation in three or more of the following areas of major life activity: (A) Self-care. (B) Receptive and expressive language. (C) Learning. (D) Mobility.	regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized. ~~ICF/ID criteria:~~ **The AEs are responsible for the completion of an initial evaluation of need for level of care. The initial evaluation will be performed by a QDDP.** ~~The ICF/ID level of care shall be indicated only when the applicant or recipient:~~ ~~(1) Requires active treatment.~~ ~~(2) Has a diagnosis of an intellectual disability.~~ ~~(3)Has been recommended for an ICF/ID level of care based on a medical evaluation.~~ **1. ICF/ID** **i. There are four fundamental criteria that must be met prior to an individual being determined eligible for an ICF/ID level of care:** **1. Have a diagnosis of intellectual disability;** **2. Intellectual disability manifested prior to age 22;** **3. Adaptive skill deficits in three or more areas of major life activity based on a standardized adaptive functioning test; and** **4. Be recommended for an ICF/ID level of care based on a medical evaluation.** ~~A diagnosis of an intellectual disability is documented by meeting the following requirements:~~ ~~(1) A licensed psychologist, certified school psychologist or a licensed physician who practices psychiatry shall certify that the applicant or recipient has significantly sub-average intellectual functioning which is documented by one of the following:~~	initial LOC evaluations and update the LOC criteria to be consistent with the ID/A waivers.

	(E) Self-direction. (F) Capacity for independent living. (G) Economic self-sufficiency. (3) It has been certified that documentation to substantiate that the applicant's or recipient's conditions were manifest before the applicant's or recipient's 22nd birthday, as established in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C.A. § 6001). ICF/ORC criteria: The ICF/ORC level of care shall be indicated only when the applicant or recipient: (1) Requires active treatment. (2) Has a diagnosis of another related condition. (3) Has been recommended for an ICF/ORC level of care based on a medical evaluation. Another related condition is defined as a severe disability, such as cerebral palsy, spina bifida, epilepsy or other similar condition manifest prior to age 22 that results in substantial limitations in at least three of the following six activities of daily living: _ self-care, _ receptive and expressive language learning, _ mobility, _ self direction and/or _ capacity for independent living The Medical Evaluation form (MA 51) is used to determine level of care	~~(i) Performance that is more than two standard deviations below the mean as measurable on a standardized general intelligence test.~~ ~~(ii) Performance that is slightly higher than two standard deviations below the mean of a standardized general intelligence test during a period when the person manifests serious impairments of adaptive behavior.~~ ~~(2) A qualified intellectual disabilities professional as defined in 42 CFR 483.430 (relating to condition of participation: facility staffing) shall certify that the applicant or recipient has impairments in adaptive behavior as provided by a standardized assessment of adaptive functioning which shows that the applicant or recipient has one of the following:~~ ~~(i) Significant limitations in meeting the standards of maturation, learning, personal independence or social responsibility of his age and cultural group.~~ ~~(ii) Substantial functional limitation in three or more of the following areas of major life activity:~~ ~~(A) Self-care.~~ ~~(B) Receptive and expressive language.~~ ~~(C) Learning.~~ ~~(D) Mobility.~~ ~~(E) Self-direction.~~ ~~(F) Capacity for independent living.~~ ~~(G) Economic self-sufficiency.~~ ~~(3) It has been certified that documentation to substantiate that the applicant's or recipient's conditions were manifest before the applicant's or recipient's 22nd birthday, as established in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C.A. § 6001).~~ ~~ICF/ORC criteria:~~ ~~The ICF/ORC level of care shall be indicated only when the applicant or recipient:~~ ~~(1) Requires active treatment.~~ ~~(2) Has a diagnosis of another related condition.~~ ~~(3) Has been recommended for an ICF/ORC level of care based on a medical evaluation.~~ ~~Another related condition is defined as a severe disability, such as cerebral palsy, spina bifida, epilepsy or other similar condition manifest prior to age 22~~	

		~~that results in substantial limitations in at least three of the following six activities of daily living:~~ ~~_ self-care,~~ ~~_ receptive and expressive language learning,~~ ~~_ mobility,~~ ~~_ self direction and/or~~ ~~_ capacity for independent living~~ **2. Autism Spectrum Disorder ICF/ORC** **i. There are four fundamental criteria that must be met prior to an individual with autism spectrum disorder being determined eligible for an ICF/ORC level of care:** **1. Have a diagnosis of autism spectrum disorder;** **2. Autism spectrum disorder manifested prior to age 22;** **3. Adaptive skill deficits in three or more areas of major life activity based on a standardized adaptive functioning test; and** **4. Be recommended for an ICF/ORC level of care based on a medical evaluation.** ~~The Medical Evaluation form (MA 51) is used to determine level of care~~	
B-6-f	**Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences: Applicants who have been determined by BAS Regional Office staff or contractors to meet program eligibility requirements specified in Appendix B-1 are evaluated by a physician using the Medical Assistance Evaluation form (MA51) to determine level of care. If the MA51 indicates a person meets ICF/IID level of care criteria, BAS will assign a Qualified Intellectual Disabilities Professional (QIDP) to assess whether the person requires ICF/IID level of care using the criteria in B-6-d.	Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences: **Initial Evaluation** **The fundamental criteria identified in Appendix B-6-d of this waiver must be met prior to an individual being determined eligible for enrollment in the waiver. The AE is responsible to certify need for an ICF/ID or ICF/ORC level of care based on the evaluation and certification of the QDDP. The following level of care criteria must be met prior to enrollment in the waiver:**	ODP is changing the initial LOC process to align with the ID/A waivers.

	For initial evaluations, BAS Regional Office staff assist physicians with completing the MA51 when necessary. For reevaluations, Supports Coordinators assist physicians with this task when necessary. This includes helping the participant to schedule the appointment with his/her physician, helping the participant to get to the appointment, reviewing the completed form to ensure that the physician completes the form accurately, answering the physician's questions, including the purpose of the form, and facilitating that the level of care form is shared with the support coordinator who keeps the original in the participant's file.	**The following four criteria must be met to document a diagnosis of autism spectrum disorder and ICF/ORC level of care and determine eligibility upon initial certification:** **1. A licensed psychologist, certified school psychologist, psychiatrist, developmental pediatrician, licensed physician, licensed physician's assistant or certified registered nurse practitioner certifies that the individual has autism spectrum disorder as documented in a diagnostic tool.** **2. A QDDP certifies that the individual has impairments in adaptive functioning based on the results of a standardized assessment of adaptive functioning which shows the individual has significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility of his or her age and cultural group. The results of the assessment must also show that the individual has substantial adaptive skill deficits in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction and/or capacity for independent living.** **3. Documentation substantiates that the individual's autism spectrum disorder and substantial adaptive skill deficits manifested during the developmental period which is from birth up to the individual's 22nd birthday.** **4. Documentation on a medical form as a result of a current medical evaluation performed by a licensed physician, physician's assistant, or certified registered nurse practitioner that states the individual is recommended for ICF/ORC level of care or documentation on a Medical Assistance Evaluation form (MA51) as a result of a current medical evaluation completed by a licensed physician, physician's assistant, or certified registered nurse practitioner that indicates the individual is recommended for an ICF/ORC level of care.** **The following four criteria must be met to document a diagnosis of intellectual disability and ICF/ID level of care and determine eligibility upon initial certification:**	

		1. A licensed psychologist, certified school psychologist, psychiatrist, developmental pediatrician, or licensed physician who practices psychiatry certifies that the individual has significantly sub-average intellectual functioning based on a standardized general intelligence test which is documented by either: **a. Performance that is more than two standard deviations below the mean of a standardized general intelligence test, which reflects a Full Scale IQ score of 70 or below; or** **b. Performance that is slightly above two standard deviations below the mean of a standardized general intelligence test during a period when the individual manifests serious impairments of adaptive functioning.** **2. A QDDP certifies that the individual has impairments in adaptive functioning based on the results of a standardized assessment of adaptive functioning which shows the individual has significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility of his or her age and cultural group. The results of the assessment must also show that the individual has substantial adaptive skill deficits in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction and/or capacity for independent living.** **3. Documentation substantiates that the individual's intellectual and substantial adaptive skill deficits manifested during the developmental period which is from birth up to the individual's 22nd birthday.** **4. Documentation on a medical form as a result of a current medical evaluation performed by a licensed physician, physician's assistant, or certified registered nurse practitioner that states the individual is recommended for ICF/ID level of care or documentation on a Medical Assistance Evaluation form (MA51) as a result of a current medical evaluation completed by a licensed physician, physician's assistant, or certified registered nurse practitioner that indicates the individual is recommended for an ICF/ID level of care.**	

		Reevaluation process Applicants who have been determined by ~~BAS Regional Office staff or contractors~~ **the AE** to meet program eligibility requirements specified in Appendix B-1, **upon enrollment and then annually** t**hereafter** are evaluated by a physician, **physician's assistant, or nurse practitioner licensed in the United States,** using the ~~Medical Assistance Evaluation form (~~MA51~~)~~ to determine level of care. **The MA51 is used to determine annual reevaluation of level of care for individuals enrolled in the AAW and must be completed within 365 days of the previous MA51.** If the MA51 indicates a person meets ICF/~~I~~ID level of care criteria, ~~BAS~~ **ODP** will assign a ~~Qualified Intellectual Disabilities Professional (~~Q~~I~~**D**~~DP~~)~~ to assess whether the person requires ICF/~~I~~ID level of care using the criteria in B-6-d. ~~For initial evaluations, BAS Regional Office staff assist physicians with completing the MA51 when necessary~~. For reevaluations, Supports Coordinators assist physicians, **physician's assistants, or certified registered nurse practitioners, licensed in the United States** with ~~this task~~ **completing the MA51** when necessary. ~~This includes helping the participant to schedule the appointment with his/her physician, helping the participant to get to the appointment, reviewing the completed form to ensure that the physician completes the form accurately, answering the physician's questions, including the purpose of the form, and facilitating that the level of care form is shared with the support coordinator who keeps the original in the participant's file.~~	
B-6-h	**Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (select one): **X The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**	Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (select one): ~~X~~ The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations. **X** The qualifications are different.	ODP made the alterations to explain the difference in qualifications between individuals

	The qualifications are different. *Specify the qualifications:*	Specify the qualifications: **Individuals who were added to the waiting list as of January 1, 2020 have initial level of care evaluations done by a QDDP possessing the qualifications described in B-6-c. Once enrolled in the waiver, level of care reevaluations may be conducted by any physician, physician's assistant, or certified registered nurse practitioner licensed in the United States.**	conducting the initial LOC determination and those conducting the reevaluations.
B-6-j	**Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained: BAS maintains copies of all level of care evaluations and reevaluations. The medical evaluation form date is logged in HCSIS and a hard copy is kept in the participant's file at each BAS regional office.	Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained: **Records of all initial level of care evaluations are maintained at the AE office where the participant is registered, per the AE Operating Agreement.** ~~BAS~~ **ODP** maintains copies of all level of care ~~evaluations and~~ reevaluations. ~~The medical evaluation form date is logged in HCSIS and a hard copy is kept in the participant's file at each BAS regional office.~~	ODP added the requirement that the AEs maintain records of initial LOC evaluations.
Appendix B: Quality Improvement: Level of Care			
B-a.i.a	Performance Measure: **Performance Measure LOC1: Number and percent of new enrollees who have a level of care (LOC) completed prior to entry into the waiver. Numerator = Number of new enrollees who have an LOC completed prior to entry into the waiver. Denominator = Number of new enrollees.** **Data Source** (Select one): **Other** If 'Other' is selected, specify: **BAS's Participant Tracking Database** **Frequency of data aggregation and analysis** *(check each that applies)*: Specify: X Annually	Performance Measure: Performance Measure LOC1: Number and percent of new enrollees who have a level of care (LOC) completed prior to entry into the waiver. Numerator = Number of new enrollees who have an LOC completed prior to entry into the waiver. Denominator = Number of new enrollees. Data Source (Select one): Other If 'Other' is selected, specify: ~~BAS's Participant Tracking Database~~ **Home and Community Services Information System (HCSIS)** Frequency of data aggregation and analysis *(check each that applies)*:	These changes were made to align with ODP's Bureau of Community Services (BCS) management of performance measure LOC1.

		Specify: **X Quarterly** X Annually	
B-a.i.c	**Performance Measure:** **Performance Measure LOC2: Number and percent of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver are used. Numerator = Number of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver are used. Denominator = Number of initial LOC determinations.** **Data Source** (Select one): **Record reviews, on-site** If 'Other' is selected, specify: **BAS paper review of MA51 forms** **Frequency of data collection/generation** *(check each that applies):* X Continuously and Ongoing	Performance Measure: Performance Measure LOC2: Number and percent of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver are used. Numerator = Number of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver are used. Denominator = Number of initial LOC determinations. Data Source (Select one): ~~Record reviews, on-site~~ If 'Other' is selected, specify: ~~BAS paper review of MA51 forms~~ **Participant record review** Frequency of data collection/generation *(check each that applies):* ~~X Continuously and Ongoing~~ **X Annually**	These changes were made to align with BCS management of performance measure LOC2.
B-a.ii	If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. BAS captures data regarding initial level of care (LOC) determination of 100% of waiver applicants in the Participant Tracking Database. That data is verified on a continuous and ongoing basis by comparing paper records of LOC to the data entered into the database. If a discrepancy is noted, BAS will correct it as necessary. BAS also reviews the paper records to ensure that the standard LOC determination instrument is used and the standard process is followed for all initial LOC determinations. If a deviation is noted, BAS will document the reason within the database.	If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. ~~BAS captures data regarding initial level of care (LOC) determination of 100% of waiver applicants in the Participant Tracking Database. That data is verified on a continuous and ongoing basis by comparing paper records of LOC to the data entered into the database. If a discrepancy is noted, BAS will correct it as necessary. BAS also reviews the paper records to ensure that the standard LOC determination instrument is used and the standard process is followed for all initial LOC determinations. If a deviation is noted, BAS will document the reason within the database.~~ **For Performance Measure LOC1, a 100% review of data from HCSIS is conducted monthly by ODP staff to assess compliance.**	These changes were made to align with BCS management of performance measure LOC1.
B-b.i-ii	**Methods for Remediation/Fixing Individual Problems** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.	Methods for Remediation/Fixing Individual Problems Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.	These changes were made to align with BCS remediation of

	Each quarter, BAS reviews information collected from the discovery activities during that quarter. BAS staff meet quarterly to discuss findings and identify remediation strategies if necessary. If there are multiple issues of performance, the BAS Director will set priorities regarding which issue to address first. If the information indicates that there are issues in timely performance or in following the level of care process, BAS will first assess whether problems are system-wide or isolated to a particular provider or region. If problems are system-wide, the BAS Director or a designee will meet with individuals involved in level of care issues, such as BAS staff and Supports Coordinators who assist physicians in completing the MA51 form. The meetings will identify systemic issues that lead to untimely performance or not following the process, and identify possible solutions such as staff training, technical assistance, more intensive monitoring, or process changes. The BAS Director or designee will then develop a quality improvement strategy to address the issue. If performance issues are isolated to only one region or provider, the BAS Director or designee will communicate with the responsible DHS staff or provider to identify the reason for the issues in performance. In addition, BAS may interview participants, family members, and providers, and/or review additional records, as necessary. The BAS Director or designee will determine corrective action based on the data collected and the previous performance of the staff person or provider. Examples of corrective action include additional training, more intensive monitoring by BAS, follow-up and resolution through a corrective action plan. For performance issues with providers, BAS will follow DHS departmental policy regarding sanctions and, if warranted, termination of the provider agreement.	~~Each quarter, BAS reviews information collected from the discovery activities during that quarter. BAS staff meet quarterly to discuss findings and identify remediation strategies if necessary. If there are multiple issues of performance, the BAS Director will set priorities regarding which issue to address first.~~ ~~If the information indicates that there are issues in timely performance or in following the level of care process, BAS will first assess whether problems are system-wide or isolated to a particular provider or region.~~ ~~If problems are system-wide, the BAS Director or a designee will meet with individuals involved in level of care issues, such as BAS staff and Supports Coordinators who assist physicians in completing the MA51 form. The meetings will identify systemic issues that lead to untimely performance or not following the process, and identify possible solutions such as staff training, technical assistance, more intensive monitoring, or process changes. The BAS Director or designee will then develop a quality improvement strategy to address the issue.~~ ~~If performance issues are isolated to only one region or provider, the BAS Director or designee will communicate with the responsible DHS staff or provider to identify the reason for the issues in performance. In addition, BAS may interview participants, family members, and providers, and/or review additional records, as necessary. The BAS Director or designee will determine corrective action based on the data collected and the previous performance of the staff person or provider. Examples of corrective action include additional training, more intensive monitoring by BAS, follow-up and resolution through a corrective action plan. For performance issues with providers, BAS will follow DHS departmental policy regarding sanctions and, if warranted, termination of the provider agreement.~~ **LOC2. ODP evaluates whether initial level of care determinations are completed accurately according to ODP policies and procedures. The AE must complete level of care evaluations using ODP's forms and processes. The AE is required to document remediation actions and submit the documentation**	performance measure LOC2.

		to ODP within 30 days. When documentation is located or completed and eligibility in any one of the criteria is not met, disenrollment procedures will be initiated as per ODP policies and procedures. If a determination is made that an AE is incorrectly applying the criteria and making determinations that are incorrect, targeted technical assistance is provided to the AE in order to ensure the AE fully understands the process and applies it correctly. ODP will initiate actions as needed to resolve any outstanding issues with AE performance using the methodology outlined in the AE Operating Agreement.	
B-7-a	**Freedom of Choice**. **a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). BAS sends notification of freedom of choice between the Adult Autism Waiver, institutional services, or no services with the application for the waiver. If an applicant is determined to meet the criteria in Appendix B-1-b, BAS will send the participant a list of Supports Coordination Agencies. The participant will choose their Supports Coordination Agency with assistance from BAS staff if necessary. The Supports Coordinator will then work with the participant and individuals he or she chooses to develop an ISP as specified in Appendix D. This process includes providing a statewide provider directory to the participant, so he or she is aware of all available providers. The Supports Coordinator will notify the participant or his or her legal representative in writing that the participant has freedom of choice among feasible service delivery alternatives. To document that the person has been notified of his or her freedom of choice, BAS developed three forms. A Waiver Service Supports Coordinator Choice Form documents the person was notified of his or her right to choose a supports coordination agency. A Service Delivery Preference Form documents	Freedom of Choice. a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). ~~BAS~~ **ODP** sends notification of freedom of choice between the Adult Autism Waiver, institutional services or no services with the application for the waiver. If an applicant is determined to meet the criteria in Appendix B-1-b, ~~BAS~~ **ODP** will send the ~~participant~~ **applicant** a list of Supports Coordination ~~Agencies~~ **Organizations when he or she receives an application for the Adult Autism Waiver.** The participant will choose their Supports Coordination ~~Agency~~ **Organization** with assistance from ~~BAS~~ **ODP** staff if necessary. The Supports Coordinator will then work with the participant and individuals he or she chooses to develop an ISP as specified in Appendix D. This process includes providing a statewide provider directory to the participant, so he or she is aware of all available providers. The Supports Coordinator will notify the participant or his or her legal representative in writing that the participant has freedom of choice among feasible service delivery alternatives. To document that the person has been notified of his or her freedom of choice, ~~BAS~~ **ODP** developed three forms. A Waiver Service Supports	ODP added language to identify when an applicant will receive the notification of freedom of choice.

	the participant's choice between waiver, institutional services, or no services. A Waiver Service Provider Choice Form documents that the person received a list of available providers and has been informed of his or her freedom to choose willing and qualified providers.	Coordinator Choice Form documents the person was notified of his or her right to choose a supports coordination agency. A Service Delivery Preference Form documents the participant's choice between waiver, institutional services, or no services. A Waiver Service Provider Choice Form documents that the person received a list of available providers and has been informed of his or her freedom to choose willing and qualified providers.	
APPENDIX C			
C-1-a: Summary of Services Covered	**Waiver Services Summary.** Service Type Service Statutory Service Day Habilitation Statutory Service Residential Habilitation Statutory Service Respite Statutory Service Supported Employment Statutory Service Supports Coordination Extended State Plan Service Therapies Other Service Assistive Technology Other Service Career Planning Other Service Community Transition Services Other Service Family Support Other Service Home Modifications Other Service Nutritional Consultation Other Service Specialized Skill Development Other Service Temporary Supplemental Services Other Service Transitional Work Services Other Service Vehicle Modifications	Waiver Services Summary. Service Type Service Statutory Service Day Habilitation Statutory Service Residential Habilitation Statutory Service Respite Statutory Service Supported Employment Statutory Service Supports Coordination Extended State Plan Service Therapies Other Service Assistive Technology Other Service Career Planning Other Service Community Transition Services Other Service Family Support Other Service Home Modifications Other Service Nutritional Consultation Other Service Specialized Skill Development Other Service Temporary Supplemental Services Other Service ~~Transitional Work Services~~ **Small Group Employment** **Other Service Transportation** Other Service Vehicle Modifications	This section is being revised to change the name of Transitional Work Services to Small Group Employment and add Transportation service.
Service Definition – Day Habilitation			
C-1/C-3: Service Specifications	**Specify applicable (if any) limits on the amount, frequency, or duration of this service:** (Language purposely omitted. Please see approved Adult Autism Waiver for full language.) Day Habilitation provides individualized assistance with acquiring, retaining, and improving communication, socialization, self-direction, self-help, and adaptive skills necessary to reside in the community. The service is expected to	Specify applicable (if any) limits on the amount, frequency, or duration of this service: Day Habilitation provides individualized assistance with acquiring, retaining, and improving communication, socialization, self-direction, self-help, and adaptive skills necessary to reside in the community. The service is expected to help the participant develop and sustain a range of valued social roles and relationships; build natural supports; increase independence; and experience meaningful community participation and inclusion. **To achieve this, each**	ODP is adding the expectation that all providers of Day Habilitation must offer each participant opportunities to participate in community

	help the participant develop and sustain a range of valued social roles and relationships; build natural supports; increase independence; and experience meaningful community participation and inclusion. This service includes: • activities to improve the participant's capacity to perform activities of daily living (i.e., bathing, dressing, eating, mobility, and using the toilet) and instrumental activities of daily living (i.e., communication, survival skills, cooking, housework, shopping, money management, time management, and use of transportation), • on-site modeling of behavior, behavior support, intensive behavior episode intervention, training, cueing, and/or supervision, • planning and coordinating a participant's daily/weekly schedule for day habilitation services, • personal assistance in completing activities of daily living and instrumental activities of daily living, and • assistance with medication administration and the performance of health-related tasks to the extent state law permits. (Language purposely omitted. Please see approved Adult Autism Waiver for full language.) Day Habilitation may not be provided in a licensed Adult Training Facility that enrolls on or after 3/17/19 and serves more than 25 individuals in the facility at any one time including individuals funded through any source. Beginning 1/1/22, Day Habilitation services may not be provided in any facility required to hold a 2380 license that serves more than 150 individuals at any one time including individuals funded through any source. **Provider Qualifications** Other Standard *(specify):* Provider staff furnishing this service must: •Be age 18 or older •If transporting participants, have a valid driver's license and automobile insurance.	**participant must be offered opportunities and needed support to participate in community activities that are consistent with the individual's preferences, choices and interests.** This service includes: • activities to improve the participant's capacity to perform activities of daily living (i.e., bathing, dressing, eating, mobility, and using the toilet) and instrumental activities of daily living (i.e., communication, survival skills, cooking, housework, shopping, money management, time management, and use of transportation), • on-site modeling of behavior, behavior support, intensive behavior episode intervention, training, cueing, and/or supervision, • planning and coordinating a participant's daily/weekly schedule for day habilitation services, • personal assistance in completing activities of daily living and instrumental activities of daily living, and • assistance with medication administration and the performance of health-related tasks to the extent state law permits. Day Habilitation may not be provided in a licensed Adult Training Facility that ~~enrolls~~ **is newly funded** on or after ~~3/17/19~~ **January 1, 2020** and serves more than 25 individuals in the facility at any one time including individuals funded through any source. Beginning 1/1/22, Day Habilitation services may not be provided in any facility required to hold a 2380 license that serves more than 150 individuals at any one time including individuals funded through any source. **Day Habilitation may not be provided in a licensed facility that enrolls on or after the effective date of 55 Pa. Code Chapter 6100 regulations in a location that is adjacent to, attached to or located in the same building as any of the following regardless of the funding source of the individuals served:** • **Hospital (medical or psychiatric).** • **Skilled Nursing Facility (55 Pa. Code Chapters 201 through 211).** • **Licensed public or private ICF/ID (55 Pa. Code Chapter 6600) or ICF/ORC.** • **Licensed Child Residential Services (55 Pa. Code Chapter 3800).**	activities that are consistent with the individual's preferences, choices and interests. This aligns with *Everyday Lives* recommendations and requirements from the Centers for Medicare and Medicaid Services. Due to the delay of 55 Pa. Code Chapter 6100 regulations, the date that newly funded licensed facilities may serve no more than 25 individuals has been moved back to January 1, 2020. ODP added clarification about where new facilities can be located to align with federal and state regulations to ensure settings are integrated in the

	•Have a high school diploma or equivalent •Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders, and meet the requirements of Title 55 PA Code Chapter 2380.	• **Licensed Community Residential Rehabilitation Services for the Mentally Ill (CRRS) (55 Pa. Code Chapter 5310).** • **Licensed Personal Care Homes (55 Pa. Code Chapter 2600).** • **Licensed Assisted Living Residences (55 pa. Code Chapter 2800).** • **Unlicensed or Licensed Family Living Homes (55 Pa. Code Chapter 6500).** • **Unlicensed or Licensed Community Homes for Individuals with an Intellectual Disability or Autism (55 Pa. Code Chapter 6400).** • **Licensed Adult Training Facilities (55 Pa. Code Chapter 2380).** • **Licensed Vocational Facilities (55 Pa. Code Chapter 2390).** • **Licensed Older Adult Daily Living Centers (6 Pa. Code Chapter 11).** Provider Qualifications Other Standard *(specify):* Provider staff furnishing this service must: •Be age 18 or older •If transporting participants, have a valid driver's license and automobile insurance. •Have a high school diploma or equivalent •~~Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders~~ **Complete standard ODP required orientation and annual training,** and meet the requirements of ~~Title~~ 55 ~~PA~~ **Pa.** Code Chapter 2380.	community and ensure participation in the community to the extent desired by each individual and in alignment with each individual's preferences, choices and interests. ODP revised the language to align with the Chapter 6100 regulations.
Service Definition-Residential Habilitation			
C-1/C-3: Service Specifications	(Language purposely omitted. Please see approved Adult Autism Waiver for full language.) Residential Habilitation is provided in a licensed facility not owned by the participant or a family member. Residential Habilitation is provided in two types of licensed facilities: •Community Homes (Group Settings) licensed under Title 55 Pennsylvania Code Chapter 6400; and •Family Living Homes licensed under Title 55 Pennsylvania Code Chapter 6500.	Residential Habilitation is provided in a licensed facility not owned by the participant or a family member. Residential Habilitation is provided in two types of licensed facilities: •~~Community Homes (Group Settings) licensed under Title 55 Pennsylvania Code Chapter 6400; and~~ **Community Homes for Individuals with an Intellectual Disability or Autism (55 Pa. Code Chapter 6400): A licensed Community Home is a home where services are provided to individuals with an intellectual disability or autism. A Community Home is defined in 55 Pa. Code Chapter 6400 as, "A building or separate dwelling unit in which residential care is provided to one or more individuals with an intellectual disability or autism".**	ODP is adding clarification about where new facilities can be located to align

	If the participant receives Specialized Skill Development Services, this service includes implementation of the behavioral support plan (BSP), the crisis intervention plan (CIP), and/or the Systematic Skill Building plan (SBP). Residential Habilitation includes collecting and recording the data necessary to support review of the ISP, the BSP and the SBP. Residential Habilitation Services must be delivered in Pennsylvania. **Specify applicable (if any) limits on the amount, frequency, or duration of this service:** Facility capacity is limited to two participants per Family Living Home. Facility capacity is limited to four or fewer participants per Community Home. A participant who is receiving Residential Habilitation services in a Community Home where that participant is the only person receiving services in that home may not also receive Specialized Skill Development/Community Support on the same day the participant is receiving Residential Habilitation (Community Home) consistent with BAS policy. All residential habilitation settings in which Residential Habilitation Services are provided must be integrated and dispersed in the community in noncontiguous locations, and may not be located on campus settings. To meet this requirement, the location of each residential habilitation setting must be separate from any other ODP-funded residential habilitation setting and must be dispersed in the community and not surrounded by, other ODP-funded residential habilitation settings. Locations that share only one common party wall are not considered contiguous. Residential habilitation settings where Residential Habilitation services are provided should be located in the community and surrounded by the general public. New residential habilitation settings or changes to existing residential habilitation settings must be approved by ODP or its designee utilizing the ODP residential habilitation setting criteria. Settings enrolled on or after the effective date of the Chapter 6100 regulations shall not be located in any development or building where more than 25% of	•Family Living Homes licensed under ~~Title~~ 55 ~~Pennsylvania~~ **Pa.** Code Chapter 6500. If the participant receives Specialized Skill Development Services, this service includes implementation of the behavioral support plan (BSP), the crisis intervention plan (CIP), and/or the Systematic Skill Building plan (SBP). Residential Habilitation includes collecting and recording the data necessary to support review of the ISP, the BSP and the SBP. Residential Habilitation Services must be delivered in Pennsylvania. Specify applicable (if any) limits on the amount, frequency, or duration of this service: Facility capacity is limited to two participants per ~~Family Living~~ **Life Sharing** Home. Facility capacity is limited to four or fewer participants per Community Home. **A setting that is a duplex, two bilevel units and two side-by-side apartments enrolled to provide waiver services on or after the effective date of 55 Pa. Code Chapter 6100 regulations shall not exceed a program capacity of 4 in both units.** A participant who is receiving Residential Habilitation services in a Community Home where that participant is the only person receiving services in that home may not also receive Specialized Skill Development/Community Support on the same day the participant is receiving Residential Habilitation (Community Home) consistent with ~~BAS~~ **ODP** policy. All residential habilitation settings in which Residential Habilitation Services are provided must be integrated and dispersed in the community in noncontiguous locations, and may not be located on campus settings. To meet this requirement, the location of each residential habilitation setting must be separate from any other ODP-funded residential habilitation setting and must be dispersed in the community and not surrounded by, other ODP-funded residential habilitation settings. Locations that share only one common party	with federal and state regulations to ensure settings are integrated in the community. The language is revised to change the name of certain services to align with the ID/A waivers.

	the apartments, condominiums or townhouses have waiver funded Residential Habilitation being provided. Service Delivery Method *(check each that applies):* Participant-directed as specified in Appendix E X Provider managed Specify whether the service may be provided by *(check each that applies):* Legally Responsible Person Relative Legal Guardian Provider Specifications: Provider Category — Provider Type Title Agency — Family Living Provider Agency — Residential Provider (Community Home) Appendix C: Participant Services C-1/C-3: Provider Specifications for Service Service Type: Statutory Service Service Name: Residential Habilitation Provider Category: Agency Provider Type: Family Living Provider **Provider Qualifications** **License** *(specify)*: Title 55 PA Code Chapter 6500 **Certificate** *(specify)*: **Other Standard** (*specify)*: Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed Adult Autism Waiver Supplemental Provider Agreement.	wall are not considered contiguous. Residential habilitation settings where Residential Habilitation services are provided should be located in the community and surrounded by the general public. New residential habilitation settings or changes to existing residential habilitation settings must be approved by ODP or its designee utilizing the ODP residential habilitation setting criteria. **Residential Habilitation may not be provided in a home enrolled on or after the effective date of 55 Pa. Code Chapter 6100 regulations that is adjacent to any of the following regardless of the funding source of the individuals served:** • **Licensed public and private (ICF/ID) (55 Pa. Code Chapter 6600) or ICF/ORC.** • **Licensed Personal Care Homes (55 Pa. Code Chapter 2600).** • **Licensed Assisted Living Residences (55 pa. Code Chapter 2800).** • **Licensed Adult Training Facilities (55 Pa. Code Chapter 2380).** • **Licensed Vocational Facilities (55 Pa. Code Chapter 2390).** • **Licensed Older Adult Daily Living Centers (6 Pa. Code Chapter 11).** **Exceptions are allowed for Residential Service locations to share one common party wall with one other Residential Service location funded through ODP's waivers in the form of a duplex, two bilevel units, and two side-by-side apartments. This exception does not extend to Residential Service locations that are not funded through ODP's waivers.** Settings enrolled on or after the effective date of the Chapter 6100 regulations shall not be located in any development or building where more than 25% of the apartments, condominiums or townhouses have waiver funded Residential Habilitation being provided. Service Delivery Method *(check each that applies)*: Participant-directed as specified in Appendix E X Provider managed Specify whether the service may be provided by *(check each that applies)*: Legally Responsible Person Relative Legal Guardian	ODP is adding clarification about where new facilities can be located to align with federal and state regulations to ensure settings are integrated in the community.

	Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute. For all provider types, individuals furnishing this service must: • Be age 18 or older • If transporting participants, have a valid driver's license and automobile insurance. • Have a high school diploma or equivalent • Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders, and meeting all requirements of Title 55 PA Code Chapter 6500. **Verification of Provider Qualifications** **Entity Responsible for Verification:** Bureau of Autism Services **Frequency of Verification:** Not more than 30 months Appendix C: Participant Services C-1/C-3: Provider Specifications for Service Service Type: Statutory Service Service Name: Residential Habilitation Provider Category: Agency Provider Type: Residential Provider (Community Home) **Provider Qualifications** **License** *(specify)*: Community Home Title 55 PA Code Chapter 6400 **Certificate** *(specify)*: **Other Standard** *(specify)*:	Provider Specifications: Provider Category Provider Type Title Agency ~~Family Living~~ **Life Sharing** Provider Agency Residential Provider (Community Home) Appendix C: Participant Services C-1/C-3: Provider Specifications for Service Service Type: Statutory Service Service Name: Residential Habilitation Provider Category: Agency Provider Type: ~~Family Living~~ **Life Sharing** Provider Provider Qualifications License *(specify)*: ~~Title~~ 55 ~~PA~~ **Pa.** Code Chapter 6500 Certificate *(specify)*: Other Standard (*specify)*: Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ~~Adult Autism~~ **ODP** Waiver ~~Supplemental~~ Provider Agreement. Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute. For all provider types, individuals furnishing this service must: • Be age 18 or older • If transporting participants, have a valid driver's license and automobile insurance. • Have a high school diploma or equivalent • ~~Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders~~ **Complete standard ODP required orientation and annual training**, and meet~~ing all~~ requirements of ~~Title~~ 55 ~~PA~~ **Pa.** Code Chapter 6500.	ODP is changing the names of certain services to align with the ID/A waivers. ODP revised the language to align with the Chapter 6100 regulations.

	Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed Adult Autism Waiver Supplemental Provider Agreement. Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute. Community Homes must have a licensed capacity to serve four or fewer residents. For all provider types, individuals furnishing this service must: • Be age 18 or older • Have a high school diploma or equivalent • If transporting participants, have a valid driver's license and automobile insurance. • Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders, and meet requirements of Title 55 PA Code Chapter 6400. The Residential Habilitation facility must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of this service. **Verification of Provider Qualifications** **Entity Responsible for Verification:** Bureau of Autism Services **Frequency of Verification:** Not more than 30 months	Verification of Provider Qualifications Entity Responsible for Verification: ~~Bureau of Autism Services~~ **ODP** Frequency of Verification: ~~Not more than 30 months~~ **At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.** Appendix C: Participant Services C-1/C-3: Provider Specifications for Service Service Type: Statutory Service Service Name: Residential Habilitation Provider Category: Agency Provider Type: Residential Provider (Community Home) Provider Qualifications License *(specify)*: ~~Community Home Title~~ 55 ~~PA~~ **Pa.** Code Chapter 6400 Certificate *(specify)*: Other Standard *(specify)*: Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ~~Adult Autism~~ **ODP** Waiver ~~Supplemental~~ Provider Agreement. Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute. Community Homes must have a licensed capacity to serve four or fewer residents. For all provider types, individuals furnishing this service must:	The frequency of the monitoring cycle has been changed to align with ODP QA&I requirements.

		• Be age 18 or older • Have a high school diploma or equivalent • If transporting participants, have a valid driver's license and automobile insurance. • ~~Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders~~ **Complete standard ODP required orientation and annual training,** and meet requirements of ~~Title~~ 55 ~~PA~~ **Pa.** Code Chapter 6400. The Residential Habilitation facility must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of this service. Verification of Provider Qualifications Entity Responsible for Verification: ~~Bureau of Autism Services~~ **ODP** Frequency of Verification: ~~Not more than 30 months~~ **At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.**	ODP revised the language to align with the Chapter 6100 regulations. The frequency of the monitoring cycle has been changed to align with ODP QA&I requirements.
Service Definition – Respite			
C-1/C-3: Service Specifications	(Language purposely omitted. Please see approved Adult Autism Waiver for full language.) **Provider Qualifications** **Other Standard** *(specify):* For all provider types, individuals furnishing this service must: • Be age 18 or older • If transporting participants, have a valid Driver's license and automobile insurance. • Have a high school diploma or equivalent • Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.	Provider Qualifications Other Standard *(specify):* For all provider types, individuals furnishing this service must: • Be age 18 or older • If transporting participants, have a valid Driver's license and automobile insurance. • Have a high school diploma or equivalent • ~~Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.~~ **Complete standard ODP required orientation and annual training.**	ODP revised the language to align with the Chapter 6100 regulations.

Service Definition – Supported Employment			
C-1/C-3: Service Specifications	Specify applicable (if any) limits on the amount, frequency, or duration of this service: Intensive Job Coaching may be authorized every 6 months for a total of 18 consecutive months. Extended Employment Supports may be authorized up to a maximum of 416 hours per year, with the year starting on the ISP authorization date. Supported Employment services cannot be provided in facilities that are not a part of the general workplace. Supported Employment does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the workplace. The total combined hours for Community Support, Day Habilitation, Transitional Work Services and Supported Employment services (Intensive Job Coaching, Direct and Extended Employment Supports, Direct) are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must request an exception to the limit consistent with BAS policy. Supported Employment (when provided directly to the participant) may not be provided at the same time that quarter hourly-reimbursed Respite, Day Habilitation, Community Support, or Transitional Work Services is provided. Supported Employment services may not be rendered under the waiver until it has been verified that: • The services are not available to the participant under a program funded by either the Rehabilitation Act of 1973, as amended by the Workforce Innovation and Opportunity Act of 2014, or the Individuals with Disabilities Education Act; • The Office of Vocational Rehabilitation (OVR) has closed the participant's case or has stopped providing services to the participant;	Specify applicable (if any) limits on the amount, frequency, or duration of this service: Intensive Job Coaching may be authorized every 6 months for a total of 18 consecutive months. Extended Employment Supports may be authorized up to a maximum of 416 hours per year, with the year starting on the ISP authorization date. Supported Employment services cannot be provided in facilities that are not a part of the general workplace. **Providers of Supported Employment services may not also be the employer of the participant to whom they provide Supported Employment.** Supported Employment does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the workplace. The total combined hours for Community Support, Day Habilitation, ~~Transitional Work Services~~ **Small Group Employment** and Supported Employment services (Intensive Job Coaching, Direct and Extended Employment Supports, Direct) are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must request an exception to the limit consistent with BAS policy. Supported Employment (when provided directly to the participant) may not be provided at the same time that quarter hourly-reimbursed Respite, Day Habilitation, Community Support, or ~~Transitional Work Services~~ **Small Group Employment** is provided. Supported Employment services may not be rendered under the waiver until it has been verified that: • The services are not available to the participant under a program funded by either the Rehabilitation Act of 1973, as amended by the Workforce	ODP is adding this language to ensure that there is no conflict of interest between an employer and provider of Supported Employment. This proposed change increases opportunities for employment by allowing a

	• It has been determined that OVR services are not available. If OVR has not made an eligibility determination within 120 days of the referral being sent, then OVR services are considered to not be available to the participant; or • The participant is determined ineligible for OVR services. A participant does not need to be referred to OVR if the participant is competitively employed and solely needs supported employment to maintain the participant's current job. Federal Financial Participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following: • Incentive payments made to an employer to encourage or subsidize the employer's participation in Supported Employment services; or • Payments that are passed through to users of Supported Employment services. (Language purposely omitted. Please see approved Adult Autism Waiver for full language.) **Provider Qualifications** **Certificate** *(specify):* **Other Standard** *(specify):* Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed Adult Autism Waiver Supplemental Provider Agreement. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania. The Supported Employment Agency must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of the Supported Employment service. Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute.	Innovation and Opportunity Act of 2014, or the Individuals with Disabilities Education Act; • The Office of Vocational Rehabilitation (OVR) has closed the participant's case or has stopped providing services to the participant; • It has been determined that OVR services are not available. If OVR has not made an eligibility determination within 120 days of the referral being sent **or a participant has received an offer of competitive integrated employment prior to OVR making an eligibility determination**, then OVR services are considered to not be available to the participant**;** or • The participant is determined ineligible for OVR services. A participant does not need to be referred to OVR if the participant is competitively employed and solely needs supported employment to maintain the participant's current job. **In the event that OVR closes the order of selection, the following process will be followed from the effective date until the closure is lifted:** **• A participant who has been referred to OVR, but does not have an approved Individualized Plan for Employment (IPE) may receive Supported Employment.** **• A participant who has not been referred to OVR may receive Supported Employment without a referral to OVR.** Federal Financial Participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following: • Incentive payments made to an employer to encourage or subsidize the employer's participation in Supported Employment services; or • Payments that are passed through to users of Supported Employment services. Provider Qualifications Certificate *(specify):* **Staff working directly with the participant must have one of the following by 7/1/2020 or within 6 months of hire if hired after 1/1/2020:** • **Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE); or**	participant who has received a job offer (where the job meets the definition of competitive integrated employment) and OVR has not made an eligibility determination at that time, to receive Supported Employment services to assist the participant in being successful in that job. This proposed change will allow individuals to receive services to obtain and sustain competitive integrated employment in the event that OVR establishes a waiting list. The waiver qualification requirements are

	Individuals furnishing Supported Employment must: • Be age 18 or older • Have a high school diploma or equivalent • If transporting participants, have a valid driver's license and automobile insurance. • Complete all required training developed by the Bureau of Autism Services regarding services for people with autism spectrum disorders and have completed required vocational training developed or approved by the Bureau of Autism Services. *Verification of Provider Qualifications* *Entity Responsible for Verification:* Bureau of Autism Services *Frequency of Verification:* Not more than 30 months	• **Have been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.** **Effective 7/1/2020, newly hired staff who do not have the required certification when hired must work under the supervision of someone who is certified. This can occur for no longer than 6 months from the date of hire to allow the new hire time to obtain the certification.** Other Standard *(specify):* Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ~~Adult Autism~~ **ODP** Waiver ~~Supplemental~~ Provider Agreement. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania. The Supported Employment Agency must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of the Supported Employment service. Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute. Individuals furnishing Supported Employment must: • Be age 18 or older • Have a high school diploma or equivalent • If transporting participants, have a valid driver's license and automobile insurance. • Complete ~~all~~ required training developed by ~~the Bureau of Autism Services regarding~~ **BAS for Employment/Vocational ~~s~~S**ervices for people with autism spectrum disorders~~ and have completed required vocational training developed or approved by the Bureau of Autism Services~~. • **Complete standard ODP required orientation and annual training.**	being revised to include certification requirements. ODP is changing the requirement of the AAW Supplemental Provider Agreement to the ODP Waiver Provider Agreement to align with the ID/A waivers.

		Verification of Provider Qualifications *Entity Responsible for Verification:* ~~Bureau of Autism Services~~ **ODP** *Frequency of Verification:* ~~Not more than 30 months~~ **At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.**	The frequency of the monitoring cycle has been changed to align with ODP QA&I requirements.
Service Definition – Supports Coordination			
C-1/C-3: Service Specifications	(Language purposely omitted. Please see approved Adult Autism Waiver for full language.) Upon completion of the initial plan, the Supports Coordinator: *Provides ongoing monitoring of the services included in the participant's ISP as described in Appendix D-2-a of the waiver. The Supports Coordinator must meet the participant in person no less than quarterly to ensure the participant's health and welfare, to review the participant's progress, to ensure that the ISP is being implemented as written, and to assess whether the team needs to revise the ISP. Within each year, at least one visit must occur in the participant's home. At least one visit must occur in a location outside the home where the participant receives services, if services are furnished outside the home. In addition, the Supports Coordinator must contact the participant, his or her guardian, or a representative designated by the participant in the ISP at least monthly, or more frequently as necessary to ensure the participant's health and welfare. These contacts may also be made in person. (Language purposely omitted. Please see approved Adult Autism Waiver for full language.) **Specify applicable (if any) limits on the amount, frequency, or duration of this service:**	Upon completion of the initial plan, the Supports Coordinator: *Provides ongoing monitoring of the services included in the participant's ISP as described in Appendix D-2-a of the waiver. The Supports Coordinator must meet the participant in person no less than quarterly to ensure the participant's health and welfare, to review the participant's progress, to ensure that the ISP is being implemented as written, and to assess whether the team needs to revise the ISP. Within each year, at least one visit must occur in the participant's home. At least one visit must occur in a location outside the home where the participant receives services, if services are furnished outside the home. In addition, the Supports Coordinator must contact the participant, his or her guardian, or a representative designated by the participant in the ISP at least monthly, or more frequently as necessary to ensure the participant's health and welfare. These contacts may also be made in person. **Monitoring the health and welfare of participants includes the review of information in health risk screening tools, when applicable, or whether there have been any changes in orders, plans or medical interventions prescribed or recommended by medical or behavioral professionals and whether those changes are being implemented**. Specify applicable (if any) limits on the amount, frequency, or duration of this service: Support Coordination may not duplicate payments made to public agencies or private entities under the Medicaid State plan or other program authorities. A	ODP is adding Transportation to the list of services in which a Supports Coordination Organization (SCO) may be enrolled as an OHCDS provider. This proposed change is to promote the health, wellness and safety of participants during monitoring by Supports Coordinators.

	Support Coordination may not duplicate payments made to public agencies or private entities under the Medicaid State plan or other program authorities. A participant's Supports Coordination Agency may not provide any other waiver services for that individual. A Supports Coordination Agency which is enrolled as an Organized Healthcare Delivery System (OHCDS) may furnish Community Transition Services, Assistive Technology, Home Modifications and Vehicle Modifications. A participant's Supports Coordination Agency may not have a fiduciary relationship with providers of the participant's other services, except for Community Transition Services, Assistive Technology, Home Modifications and Vehicle Modifications. A participant's Supports Coordination Agency may not own or operate providers of Community Transition Services, Assistive Technology, Home Modifications, and Vehicle Modifications with which it is acting as an OHCDS. **Provider Qualifications** **Other Standard** *(specify):* Individuals furnishing this service must: •Have at least a Bachelor's degree in Education, Psychology, Social Work, or other related social sciences. •Have either 1) at least three years' experience providing case management for people with disabilities or 2) at least three years' experience working with people with autism spectrum disorders •If transporting participants, have a valid driver's license and automobile insurance. •Complete required training developed or approved by the Bureau of Autism Services for Supports Coordination for people with autism spectrum disorders, including training in needs assessment and person-centered planning	participant's Supports Coordination ~~Agency~~ **Organization** may not provide any other waiver services for that individual. A Supports Coordination ~~Agency~~ **Organization** which is enrolled as an Organized Healthcare Delivery System (OHCDS) may furnish Community Transition Services, Assistive Technology, Home Modifications**, Transportation** and Vehicle Modifications. A participant's Supports Coordination ~~Agency~~ **Organization** may not have a fiduciary relationship with providers of the participant's other services, except for Community Transition Services, Assistive Technology, Home Modifications**, Transportation** and Vehicle Modifications. A participant's Supports Coordination ~~Agency~~ **Organization** may not own or operate providers of Community Transition Services, Assistive Technology, Home Modifications**, Transportation** and Vehicle Modifications with which it is acting as an OHCDS. Provider Qualifications Other Standard *(specify):* Individuals furnishing this service must: •Have at least a Bachelor's degree in Education, Psychology, Social Work, or other related social sciences. •Have either 1) at least three years' experience providing case management for people with disabilities or 2) at least three years' experience working with people with autism spectrum disorders •If transporting participants, have a valid driver's license and automobile insurance. •Complete required training developed ~~or approved~~ by ~~the Bureau of Autism Services~~ **BSASP** for **AAW** Supports Coordination for people with autism spectrum disorders**.**~~, including training in needs assessment and person-centered planning~~ **•Complete standard ODP required orientation and annual training.**	
Service Definition – Therapies			
C-1/C-3: Service Specifications	(Language purposely omitted. Please see approved Adult Autism Waiver for full language.) **Provider Qualifications** **Other Standard** *(specify):*	Provider Qualifications Other Standard *(specify):* ~~In addition, i~~**I**ndividuals providing these services must ~~complete required training developed or approved by BAS regarding services for people with ASD~~ **complete standard ODP required orientation and annual training**.	ODP revised the language to align with the Chapter 6100 regulations.

	In addition, individuals providing these services must complete required training developed or approved by BAS regarding services for people with ASD.		
Service Definition – Career Planning			
C-1/C-3: Service Specifications	**Specify applicable (if any) limits on the amount, frequency, or duration of this service:** Career Planning services may not be rendered under the waiver until it has been verified that the services are: • Not available to the participant under a program funded by either the Rehabilitation Act of 1973, as amended by the Workforce Innovation and Opportunity Act of 2014, or the Individuals with Disabilities Education Act; • The Office of Vocational Rehabilitation (OVR) has closed the participant's case or has stopped providing services to the participant; •It has been determined that OVR services are not available. If OVR has not made an eligibility determination within 120 days of the referral being sent, then OVR services are considered to not be available to the participant; or • The participant is determined ineligible for OVR services. A participant does not need to be referred to OVR if the participant is competitively employed and is seeking career planning services to find a new job. Federal Financial Participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following: • Incentive payments made to an employer to encourage or subsidize the employer's participation in Vocational Assessment services; or • Payments that are passed through to users of Vocational Assessment services. (Language purposely omitted. Please see approved Adult Autism Waiver for full language.) **Provider Qualifications** **Certificate** *(specify):* **Other Standard** *(specify):* Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed Adult Autism Waiver Supplemental Provider Agreement.	Specify applicable (if any) limits on the amount, frequency, or duration of this service: Career Planning services may not be rendered under the waiver until it has been verified that the services are: • Not available to the participant under a program funded by either the Rehabilitation Act of 1973, as amended by the Workforce Innovation and Opportunity Act of 2014, or the Individuals with Disabilities Education Act; • The Office of Vocational Rehabilitation (OVR) has closed the participant's case or has stopped providing services to the participant; • It has been determined that OVR services are not available. If OVR has not made an eligibility determination within 120 days of the referral being sent, then OVR services are considered to not be available to the participant; or • The participant is determined ineligible for OVR services. A participant does not need to be referred to OVR if the participant is competitively employed and is seeking career planning services to find a new job**, unless the purpose is job advancement which can be provided by OVR.** **In the event that OVR closes the order of selection, the following process will be followed from the effective date until the closure is lifted:** **• A participant who has been referred to OVR, but does not have an approved Individualized Plan for Employment (IPE) may receive Career Planning services.** **• A participant who has not been referred to OVR may receive Career Planning services without a referral to OVR.** Federal Financial Participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following: • Incentive payments made to an employer to encourage or subsidize the employer's participation in ~~Vocational Assessment~~ **Career Planning** services; or • Payments that are passed through to users of ~~Vocational Assessment~~ **Career Planning** services.	OVR provides assistance with job advancement and therefore a participant needs to be referred to OVR if they are interested in job advancement. This proposed change will allow individuals to receive services to obtain and sustain competitive integrated employment in the event that OVR establishes a waiting list.

	Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania. Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute. The Career Planning Agency must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of the Career Planning service. Individuals furnishing this service must: A Bachelor's degree or higher in rehabilitation, business, or marketing; or Have a Bachelor's degree in a field related to rehabilitation, business or marketing and 1 year of experience that can be verified related to job assessment, job finding or employment supports, or A Bachelor's degree in Education, Psychology or other related social sciences and 1 year of experience that can be verified related to job assessment, job finding or employment supports; or An Associate's degree in rehabilitation, business, marketing or field related to rehabilitation, business or marketing and 2 years of documented experience related to job assessment, job finding or employment supports; or An Associate's degree or higher in any field and 5 years of experience that can be verified related to job assessment, job finding or employment supports; Completion of required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders, including training in providing a situational vocational assessment. If transporting participants, have a valid driver's license and automobile insurance. *Verification of Provider Qualifications* *Entity Responsible for Verification:* Bureau of Autism Services *Frequency of Verification:*	Provider Qualifications Certificate *(specify):* **Staff working directly with the participant must have one of the following by 7/1/2020 or within 6 months of hire if hired after 1/1/2020:** **• Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE); or** **• Have been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.** **Effective 7/1/2020, newly hired staff who do not have the required certification when hired must work under the supervision of someone who is certified. This can occur for no longer than 6 months from the date of hire to allow the new hire time to obtain the certification.** Other Standard *(specify):* Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ~~Adult Autism~~ **ODP** Waiver ~~Supplemental~~ Provider Agreement. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania. Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute. The Career Planning Agency must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of the Career Planning service. Individuals furnishing this service must: ~~A Bachelor's degree or higher in rehabilitation, business, or marketing; or~~	The waiver qualification requirements are being revised to include certification requirements. Based on public comment received, ODP is changing the requirement from Bachelor's or Associate's degree, to high school diploma or equivalent. This change can be made without

	Not more than 30 months	~~-Have a Bachelor's degree in a field related to rehabilitation, business or marketing and 1 year of experience that can be verified related to job assessment, job finding or employment supports, or~~ ~~-A Bachelor's degree in Education, Psychology or other related social sciences and 1 year of experience that can be verified related to job assessment, job finding or employment supports; or~~ ~~-An Associate's degree in rehabilitation, business, marketing or field related to rehabilitation, business or marketing and 2 years of documented experience related to job assessment, job finding or employment supports; or~~ ~~-An Associate's degree or higher in any field and 5 years of experience that can be verified related to job assessment, job finding or employment supports;~~ **-Have a high school diploma or equivalent; and** -Complet~~eion of~~ required training developed ~~or approved~~ by the Bureau of **Supports for** Autism ~~Services~~ **and Special Populations (BSASP)** ~~regarding~~ **for Employment/Vocational** ~~s~~**S**ervices for people with autism spectrum disorders~~,~~ ~~including training in providing a situational vocational assessment~~. **-Complete standard ODP required orientation and annual training.** -If transporting participants, have a valid driver's license and automobile insurance. *Verification of Provider Qualifications* *Entity Responsible for Verification:* ~~Bureau of Autism Services~~ **ODP** *Frequency of Verification:* ~~Not more than 30 months~~ **At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.**	sacrificing quality of services to participants, as staff working directly with a participant will have to complete certification requirements as proposed in the amendment. This change aligns with the staff qualifications in the other ODP waivers and will better support participants in the AAW to achieve competitive integrated employment. ODP revised the language to align with the Chapter 6100 regulations. The frequency of the monitoring cycle has been changed to align with ODP Quality Assessment & Improvement

			(QA&I) requirements.
Service Definition – Family Support			
C-1/C-3: Service Specifications	This service provides counseling and training for the participant's family and informal network to help develop and maintain healthy, stable relationships among all members of the participant's informal network, including family members, and the participant in order to support the participant in meeting the goals in the participant's ISP. Family Support assists the participant's family and informal care network with developing expertise so that they can help the participant acquire, retain or improve skills that directly improve the participant's ability to live independently. Emphasis is placed on the acquisition of coping skills, stress reduction, improved communication, and environmental adaptation by building upon family and informal care network strengths. The waiver may not pay for services for which a third party, such as the family members' health insurance, is liable. The Family Support service does not pay for someone to attend an event or conference. Family Support must be necessary to achieve the expected outcomes identified in the participant's ISP. The Family Support provider must update the Supports Coordinator at least monthly regarding progress toward the goals for the Family Support service. The Supports Coordinator will summarize monthly progress in the Quarterly Summary Report submitted into HCSIS. The Family Support provider must maintain monthly notes in the participant's file and have them available for review by BAS during monitoring. If the participant receives Specialized Skill Development/Behavioral Specialist Services, the Family Support provider must provide this service in a manner consistent with the participant's behavioral support plan and crisis intervention plan. This service may be delivered in Pennsylvania and in states contiguous to Pennsylvania. **Specify applicable (if any) limits on the amount, frequency, or duration of this service:**	This service provides counseling and training for the participant's family and informal network to help develop and maintain healthy, stable relationships among all members of the participant's informal network, including family members, and the participant in order to support the participant in meeting the goals in the participant's ISP. Family Support assists the participant's family and informal care network with developing expertise so that they can help the participant acquire, retain or improve skills that directly improve the participant's ability to live independently. Emphasis is placed on the acquisition of coping skills, stress reduction, improved communication, and environmental adaptation by building upon family and informal care network strengths. The waiver may not pay for services for which a third party, such as the family members' health insurance, is liable. The Family Support service does not pay for someone to attend an event or conference. Family Support must be necessary to achieve the expected outcomes identified in the participant's ISP. The Family Support provider must update the Supports Coordinator at least monthly regarding progress toward the goals for the Family Support service. ~~The Supports Coordinator will summarize monthly progress in the Quarterly Summary Report submitted into HCSIS.~~ The Family Support provider must maintain monthly notes in the participant's file and have them available for review by BAS during monitoring. If the participant receives Specialized Skill Development/Behavioral Specialist Services, the Family Support provider must provide this service in a manner consistent with the participant's behavioral support plan and crisis intervention plan. This service may be delivered in Pennsylvania and in states contiguous to Pennsylvania. Specify applicable (if any) limits on the amount, frequency, or duration of this service:	The waiver definition is being revised to remove outdated language and align with the Chapter 6100 regulations.

	The Family Support Services may be authorized for a maximum of 40 hours per year, with the year starting on the ISP authorization date. This limitation generally would not impact participant's health and welfare. In the event that Family Support services would be needed beyond the above limits in order to assure health and welfare, based on the family's request or provider assessment that additional services would be needed, the Supports Coordinator will convene an ISP meeting of the participant, and other team members to explore alternative resources to assure the participant's health and welfare through other supports and services as outlined in Appendix D. **Provider Qualifications** **Other Standard** *(specify):* (Language purposely omitted. Please see approved Adult Autism Waiver for full language.) Individuals within the agency furnishing this service must: •Have one of the licenses described herein •Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.	The Family Support Services may be authorized for a maximum of 40 hours per year, with the year starting on the ISP authorization date. This limitation generally would not impact participant's health and welfare. In the event that Family Support services would be needed beyond the above limits in order to assure health and welfare, based on the family's request or provider assessment that additional services would be needed, the Supports Coordinator will convene an ISP meeting of the participant, and other team members to explore alternative resources to assure the participant's health and welfare through other supports and services as outlined in Appendix D. Provider Qualifications Other Standard *(specify):* Individuals within the agency furnishing this service must: ~~•Have one of the licenses described herein~~ ~~•Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.~~ **Complete standard ODP required orientation and annual training.**	
Service Definition – Nutritional Consultation			
C-1/C-3: Service Specifications	(Language purposely omitted. Please see approved Adult Autism Waiver for full language.) **Provider Qualifications** **Other Standard** *(specify):* In addition to licensure, individuals furnishing this service must: Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.	Provider Qualifications Other Standard *(specify):* In addition to licensure, individuals furnishing this service must: ~~Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders~~ **Complete standard ODP required orientation and annual training**.	ODP revised the language to align with the Chapter 6100 regulations.
Service Definition – Specialized Skill Development			
C-1/C-3: Service Specifications	(Language purposely omitted. Please see approved Adult Autism Waiver for full language.) **Provider Qualifications** **Other Standard** *(specify):*	Provider Qualifications Other Standard *(specify):* Providers of Behavioral Specialist services must: • **Have** ~~Aa~~ Pennsylvania Behavior Specialist License OR	ODP revised the language to align with the Chapter 6100 regulations.

	Providers of Behavioral Specialist services must: •A Pennsylvania Behavior Specialist License OR A Master's Degree in Social Work, Psychology, Education, or Applied Behavior Analysis OR A Master's Degree with 50% or more coursework in Applied Behavior Analysis OR A Master's Degree in a human services field related to Social Work, Psychology or Education (and is housed in the institution's Department or School of Social Work, Psychology, or Education) with 33% or more coursework in Applied Behavior Analysis •Complete training in conducting and using a Functional Behavioral Assessment (FBA) and in positive behavioral support. The training must be provided by either the BAS or by an accredited college or university. If this training was not provided by the BAS, BAS must review and approve the course description. •Complete required training developed by the BAS regarding Behavioral Specialist Services for people with ASD and other trainings required for the Behavioral Specialist Service. •If transporting a participant, have a valid driver's license and automobile insurance. Providers of Systematic Skill Building must: •Have at least a Bachelor's Degree in Social Work, Psychology, Education, or a human services field related to Social Work, Psychology or Education or at least a Bachelor's Degree in another field and 3 or more years' experience directly supporting individuals with ASD in the community; •Complete required training developed by the BAS regarding Systematic Skill Building for people with ASD and other trainings required for the Systematic Skill Building service. •If transporting participants, have a valid driver's license and automobile insurance. Providers of Community Support must: •Be at least 18 years old;	A Master's Degree in Social Work, Psychology, Education, or Applied Behavior Analysis OR A Master's Degree with 50% or more coursework in Applied Behavior Analysis OR A Master's Degree in a human services field related to Social Work, Psychology or Education (and is housed in the institution's Department or School of Social Work, Psychology, or Education) with 33% or more coursework in Applied Behavior Analysis •Complete training in conducting and using a Functional Behavioral Assessment (FBA) and in positive behavioral support. The training must be provided by either the B**S**AS**P** or by an accredited college or university. If this training was not provided by the B**S**AS**P**, ~~BAS~~ **ODP** must review and approve the course description. •Complete required training developed by ~~the~~ B**S**AS**P** ~~regarding~~ **for Specialized Skill Development (SSD):** Behavioral Specialist Services for people with **autism spectrum disorders** ~~ASD and other trainings required for the Behavioral Specialist Service~~. **•Complete standard ODP required orientation and annual training.** •If transporting a participant, have a valid driver's license and automobile insurance. Providers of Systematic Skill Building must: •Have at least a Bachelor's Degree in Social Work, Psychology, Education, or a human services field related to Social Work, Psychology or Education or at least a Bachelor's Degree in another field and 3 or more years' experience directly supporting individuals with ASD in the community; •Complete required training developed by ~~the~~ B**S**AS**P** ~~regarding~~ **for SSD:** Systematic Skill Building **services** for people with **autism spectrum disorders.** ~~ASD and other trainings required for the Systematic Skill Building service.~~ **•Complete standard ODP required orientation and annual training.** •If transporting participants, have a valid driver's license and automobile insurance. Providers of Community Support must: •Be at least 18 years old;	

	•If transporting participants, have a valid driver's license and automobile insurance. •Have at least a high school degree or equivalent; •Complete all required training developed by the Bureau of Autism Services for people with ASD and other trainings required for the Community Support service.	•If transporting participants, have a valid driver's license and automobile insurance. •Have at least a high school degree or equivalent; •~~Complete all required training developed by the Bureau of Autism Services for people with ASD and other trainings required for the Community Support service.~~ **Complete standard ODP required orientation and annual training.**	
Service Definition – Temporary Supplemental Services			
C-1/C-3: Service Specifications	(Language purposely omitted. Please see approved Adult Autism Waiver for full language.) **Provider Qualifications** **Other Standard** *(specify):* Temporary Crisis services staff must: •Be age 18 or older •Have a high school diploma or equivalent •Complete required training developed by the Bureau of Autism Services regarding services for people with autism spectrum disorders. •If transporting participants, have a valid driver's license and automobile insurance.	Provider Qualifications Other Standard *(specify):* Temporary Crisis services staff must: •Be age 18 or older •Have a high school diploma or equivalent •~~Complete required training developed by the Bureau of Autism Services regarding services for people with autism spectrum disorders~~. **Complete standard ODP required orientation and annual training.** •If transporting participants, have a valid driver's license and automobile insurance.	ODP revised the language to align with the Chapter 6100 regulations.
Service Definition – Small Group Employment			
C-1/C-3: Service Specifications	Transitional Work Services provide community employment opportunities in which the participant is working alongside other people with disabilities. The intent of this service is to support individuals in transition to competitive integrated employment. Transitional Work Services may not be provided in a facility subject to Title 55, Chapter 2380 or Chapter 2390 regulations. Transitional Work Services do not include Supported Employment services. Participants must be paid at least minimum wage and the compensation must be similar to compensation earned by workers without disabilities performing the same work. Transitional work service options include: mobile work force, work station in industry, affirmative industry, and enclave.	~~Transitional Work~~ **Small Group Employment** ~~S~~services **are direct services that** provide community employment opportunities in which the participant is working alongside other people with disabilities. The intent of this service is to support individuals in transition to competitive integrated employment. ~~Transitional Work Services~~ **Small Group Employment** may not be provided in a facility subject to Title 55, Chapter 2380 or Chapter 2390 regulations. ~~Transitional Work Services~~ **Small Group Employment** do**es** not include Supported Employment services. Participants must be paid at least minimum wage and the compensation must be similar to compensation earned by workers without disabilities performing the same work. ~~Transitional work Service~~ **Small Group Employment** options include: mobile work force, work station in industry, affirmative industry, and enclave. **Small Group Employment services are only billable when the participant is**	ODP is changing the name of this service from Transitional Work Services to Small Group Employment to align with the ID/A waivers. ODP is adding clarification

	A Mobile Work Force uses teams of individuals, supervised by a training/job supervisor, who conduct service activities away from an agency or facility. The provider agency contracts with an outside organization or business to perform maintenance, lawn care, janitorial services, or similar tasks and the individuals are paid by the provider. A Work Station in Industry involves individual or group training of individuals at an industry site. Training is conducted by a provider training/job supervisor or by a representative of the industry, and is phased out as the individual(s) demonstrate job expertise and meet established work standards. A Work Station in Industry is an employment station arranged and supported by a provider within a community business or industry site, not within a licensed facility site. An example would be three seats on an assembly line within a computer chip assembly factory. The provider has a contract with the business to ensure that those three seats are filled by adults that they support. Affirmative Industry is a business that sells products or services where at least 51% of the employees do not have a disability. Enclave is a business model where participants are employed by a business/industry to perform specific job functions while working alongside workers without disabilities. Transitional Work Services include supporting the participant with personal care needs that cannot, or would be inappropriate to, be provided with the support from coworkers or other natural supports. The service includes transportation that is an integral component of the service, for example, transportation to a work site. Transitional Work Services must be necessary to achieve the expected outcomes identified in the participant's ISP. The Supports Coordinator must review this service at least quarterly, in conjunction with the participant, to assure that expected outcomes are met, to ensure the participant is aware of employment options, and to modify the ISP as necessary. The review must include an assessment of the participant's progress, identification of needs, and plans to address those needs. It is the participant's and services	**receiving direct support during the time that he or she is working and receiving wages through one of these service options or during transportation to a work site.** A Mobile Work Force uses teams of individuals, supervised by a training/job supervisor, who conduct service activities away from an agency or facility. The provider agency contracts with an outside organization or business to perform maintenance, lawn care, janitorial services, or similar tasks and the individuals are paid by the provider. A Work Station in Industry involves individual or group training of individuals at an industry site. Training is conducted by a provider training/job supervisor or by a representative of the industry, and is phased out as the individual(s) demonstrate job expertise and meet established work standards. A Work Station in Industry is an employment station arranged and supported by a provider within a community business or industry site, not within a licensed facility site. An example would be three seats on an assembly line within a computer chip assembly factory. The provider has a contract with the business to ensure that those three seats are filled by adults that they support. Affirmative Industry is a business that sells products or services where at least 51% of the employees do not have a disability. Enclave is a business model where participants are employed by a business/industry to perform specific job functions while working alongside workers without disabilities. ~~Transitional Work Services~~ **Small Group Employment** include**s** supporting the participant with personal care needs that cannot, or would be inappropriate to, be provided with the support from coworkers or other natural supports. The service includes transportation that is an integral component of the service, for example, transportation to a work site. ~~Transitional Work Services~~ **Small Group Employment** must be necessary to achieve the expected outcomes identified in the participant's ISP. The	regarding when Small Group Employment can be billed.

	providers' responsibility to notify the Supports Coordinator of any changes in the employment activities and to provide the Supports Coordinator with copies of the referenced evaluation. The cost of transportation provided by staff to and from job sites is included in the rate paid to the program provider. If the participant receives Specialized Skill Development services, this service includes implementation of the behavioral support plan (BSP), the crisis intervention plan (CIP) and/or the Systematic Skill Building plan (SBP). The service includes collecting and recording the data necessary to support review of the ISP, BSP and the SBP. Transitional Work services may be provided without referring a participant to OVR unless the participant is under the age of 25. When a participant is under the age of 25, Transitional Work Services may only be authorized as a new service in the ISP when documentation has been obtained that OVR has closed the participant's case, has stopped providing services to the participant, or that the participant has been determined ineligible for OVR services. Transitional Work Services may not be provided at the same time that quarter hourly-reimbursed Respite, Day Habilitation, Community Support, or Supported Employment service (when provided directly to the participant) is provided. (Language purposely omitted. Please see approved Adult Autism Waiver for full language.) **Provider Qualifications** **Certificate** *(specify):* **Other Standard** *(specify):* Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed Adult Autism Waiver Supplemental Provider Agreement.	Supports Coordinator must review this service at least quarterly, in conjunction with the participant, to assure that expected outcomes are met, to ensure the participant is aware of employment options, and to modify the ISP as necessary. The review must include an assessment of the participant's progress, identification of needs, and plans to address those needs. It is the participant's and services providers' responsibility to notify the Supports Coordinator of any changes in the employment activities and to provide the Supports Coordinator with copies of the referenced evaluation. The cost of transportation provided by staff to and from job sites is included in the rate paid to the program provider. If the participant receives Specialized Skill Development services, this service includes implementation of the behavioral support plan (BSP), the crisis intervention plan (CIP) and/or the Systematic Skill Building plan (SBP). The service includes collecting and recording the data necessary to support review of the ISP, BSP and the SBP. **Effective 7/1/19,** ~~Transitional Work services~~ **Small Group Employment** may be provided without referring a participant to OVR **as OVR does not provide Small Group Employment services.** ~~unless the participant is under the age of 25. When a participant is under the age of 25, Transitional Work Services may only be authorized as a new service in the ISP when documentation has been obtained that OVR has closed the participant's case, has stopped providing services to the participant, or that the participant has been determined ineligible for OVR services.~~ ~~Transitional Work Services~~ **Small Group Employment** may not be provided at the same time that quarter hourly-reimbursed Respite, Day Habilitation, Community Support, or Supported Employment service (when provided directly to the participant) is provided. Provider Qualifications Certificate *(specify):* **Staff working directly with the participant to provide Small Group Employment services must have one of the following by 7/1/2020 or within 6 months of hire if hired after 1/1/2020:**	Individuals who receive Small Group Employment services do not need to be referred to OVR since OVR does not provide Small Group Employment services. The waiver qualification requirements are

	Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania. Individuals furnishing this service must: •Be age 18 or older •If transporting participants, have a valid driver's license and automobile insurance. •Have a high school diploma or equivalent •Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders. The Transitional Work Services Agency must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of this service. *Verification of Provider Qualifications* *Entity Responsible for Verification:* Bureau of Autism Services *Frequency of Verification:* Not more than 30 months	• **Hold a Certified Employment Support Professional (CESP) credential from the Association of People Supporting Employment First (APSE); or** • **Have been awarded a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators (ACRE) organizational member that has ACRE-approved training.** **Effective 7/1/2020, newly hired staff who do not have the required certification when hired must work under the supervision of someone who is certified. This can occur for no longer than 6 months from the date of hire to allow the new hire time to obtain the certification.** Other Standard *(specify):* Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ~~Adult Autism~~ **ODP** Waiver ~~Supplemental~~ Provider Agreement. Carry commercial general liability insurance, professional liability errors and omissions insurance and worker's compensation insurance when required by Pennsylvania statute. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania. Individuals furnishing this service must: •Be age 18 or older •If transporting participants, have a valid driver's license and automobile insurance. •Have a high school diploma or equivalent •~~Complete required training developed or approved by the Bureau of Autism Services regarding services for people with autism spectrum disorders.~~ **Complete standard ODP required orientation and annual training.** The ~~Transitional Work~~ **Small Group Employment** ~~S~~services Agency must have automobile insurance for all automobiles owned, leased, and/or hired used as a component of this service.	being revised to include certification requirements.

		Verification of Provider Qualifications *Entity Responsible for Verification:* ~~Bureau of Autism Services~~ **ODP** *Frequency of Verification:* ~~Not more than 30 months~~ **At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.**	The frequency of the monitoring cycle has been changed to align with ODP QA&I requirements.
C-1/C-3: Service Specifications	**Transportation is a direct service that enables participants to access services and activities specified in their approved service plan. This service does not include transportation that is an integral part of the provision of another discrete Waiver service.** **The Transportation service consists of:** **1. Public Transportation. Public transportation services are vendor services provided to or purchased for participants to enable them to gain access to services, activities in the community and resources as specified in their service plans. Public transportation may be purchased by an OHCDS when the public transportation vendor does not elect to enroll directly.** **2. Transportation-Trip. This service is transportation provided to participants for which costs are determined on a per trip basis. A trip is defined as transportation from a participant's home, a waiver service, activity in the community or resource specified in the participant's service plan to a waiver service, activity in the community or resource specified in the participant's service plan or the participant's home. Transportation may be used to travel to and from a job that meets the definition of competitive integrated employment. Taking a participant to a destination and returning the participant to his/her home is considered two trips or two units of service. Trip distances are defined by ODP through the use of zones. Zones are defined as follows:** • **Zone 1 - greater than 0 and up to 10 miles;** • **Zone 2 - greater than 10 miles and up to 30 miles; and** • **Zone 3 – over 30 miles.** **Providers that transport more than 6 participants are required to have an aide in the vehicle. If a provider transports 6 or fewer participants, the provider has the discretion to determine if an aide is required. The determination must be based upon the needs of the participants, the provider's ability to ensure the health and welfare of participants and be consistent with ODP requirements for safe transportation.** **Participants authorized to receive Transportation services may not receive the direct provision of the following services at the same time they are receiving Transportation: Day Habilitation, Supported Employment, Therapies, Career Planning, Family Support, Nutritional Consultation, Specialized Skill Development, and Small Group Employment.**		A new service is being added to align with the ID/A waiver services.

	Participants authorized to receive Residential Habilitation or Life Sharing services may only be authorized for Transportation services as a discrete service when the participant requires transportation to or from a job that meets the definition of competitive integrated employment. **Transportation services may not be substituted for the transportation services that a state is obligated to furnish under the requirements of 42 CFR § 431.53 regarding transportation to and from providers of Medical Assistance services.** **This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania.** *Specify applicable (if any) limits on the amount, frequency, or duration of this service:* **Expenditure for Transportation is limited to $4,500 per participant's service plan year.** *Provider Qualifications* **Agency** *License (specify):* *Certificate (specify):* **Agencies must have Public Utility Commission (PUC) Certification, when required by state law or comparable certificate in contiguous states.** *Other Standard (specify):* **Agencies must meet the following standards:** **1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.** **2. Have a signed ODP Waiver Provider Agreement on file with ODP.** **3. Complete standard ODP required orientation and annual training.** **4. New providers demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures. Public transportation providers are exempt from this requirement.** **5. Have Commercial General Liability Insurance.** **6. Have documentation that all vehicles used in the provision of Transportation services have automobile insurance.** **7. Have documentation that all vehicles used in the provision of Transportation services have current State motor vehicle registration and inspection.** **8. Have Workers' Compensation Insurance, in accordance with state law.** **9. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.** **10. Comply with Department standards related to provider qualifications.** **Drivers and aides working for or contracted with agencies as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:** **1. Be at least 18 years of age.**	

	2. Have criminal history clearances per 35 P.S. § 10225.101 et seq. and 6 Pa. Code Chapter 15. **3. Have a valid driver's license if the operation of a vehicle is necessary to provide Transportation services.** *Verification of Provider Qualifications Entity Responsible for Verification:* **OHCDS for public Transportation and Transportation-Trip.** **ODP or its Designee for all types of Transportation providers that enroll directly with the Department.** *Frequency of Verification:* **At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.**		
Service Definition – Changes to All Services			
C-1/C-3: Service Specifications	*Provider Qualifications* *Other Standard (specify):* Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed Adult Autism Waiver Supplemental Provider Agreement. (Language purposely omitted. Please see approved Adult Autism Waiver for full language.) *Verification of Provider Qualifications* *Frequency of Verification:* Not more than 30 months	*Provider Qualifications* *Other Standard (specify):* Agencies Providing Waiver services will have a signed Medical Assistance Provider Agreement and a signed ~~Adult Autism~~ **ODP** Waiver ~~Supplemental~~ Provider Agreement. **After July 1, 2019, providers must demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures.** *Verification of Provider Qualifications* *Frequency of Verification:* ~~Not more than 30 months~~ **At least once during a 3-year monitoring cycle and more frequently when deemed necessary by ODP. New providers may be qualified more frequently depending on which monitoring cycle they are assigned.**	ODP is aligning the AAW with the ODP QA&I requirements. The frequency of the monitoring cycle has been changed to align with ODP QA&I requirements.
C-2-e	**Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.** Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the	Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the	

	services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.* Family members – defined as parents, children, stepparents, stepchildren, grandparents, grandchildren, brothers, sisters, half brothers, half sisters, aunts, uncles, nieces or nephews may provide Community Support and Respite as employees of a provider agency providing these services. (Language purposely omitted. Please see approved Adult Autism Waiver for full language.)	services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.* Family members – defined as parents, children, stepparents, stepchildren, grandparents, grandchildren, brothers, sisters, half brothers, half sisters, aunts, uncles, nieces or nephews may provide Community Support and Respite as employees of a provider agency providing these services. **Family members may provide Transportation-Trip through an OHCDS.**	ODP is adding Transportation-Trip as a service that can be provided by a relative or legal guardian.
Appendix C: Participant Services-Quality Improvement: Qualified Providers			
C-a.i.b	**Performance Measure QP2: Number and percent of direct support professionals who meet age, education, experience, and criminal background check requirements per Appendix C prior to service delivery. Numerator = Number of DSPs who meet age, education, experience, and criminal background check requirements per Appendix C prior to service delivery. Denominator = Number of DSPs reviewed.** **Data Source** (Select one): **Other** If 'Other' is selected, specify: **Provider Monitoring**	Performance Measure QP2: Number and percent of ~~direct support professionals~~ **providers** who meet age, education, experience, and criminal background check requirements per Appendix C prior to service delivery. Numerator = Number of ~~DSPs~~ **providers** who meet age, education, experience, and criminal background check requirements per Appendix C prior to service delivery. Denominator = Number of ~~DSPs~~ **providers** reviewed. Data Source (Select one): Other If 'Other' is selected, specify: ~~Provider Monitoring~~ **QA&I Process**	ODP is evaluating other providers in addition to direct support professionals (DSP) in this measure. The language change accurately reflects the evaluation that is done. The data source is changing to the QA&I Process since it is replacing the provider monitoring process in the AAW.
C-a.i.c	**Performance Measure QP3: Number and percent of DSPs who completed required training. Numerator = Number of DSPs who completed required training. Denominator = Number of DSPs reviewed.**	Performance Measure QP3: Number and percent of ~~DSPs~~ **providers** who completed required training. Numerator = Number of ~~DSPs~~ **providers** who completed required training. Denominator = Number of ~~DSPs~~ **providers** reviewed.	ODP is evaluating other providers in addition to DSPs in this measure. The

	Data Source (Select one): **Other** If 'Other' is selected, specify: **Provider Monitoring**	Data Source (Select one): Other If 'Other' is selected, specify: ~~Provider Monitoring~~ **QA&I Process**	language change accurately reflects the evaluation that is done. The data source is changing to the QA&I Process since it is replacing the provider monitoring process in the AAW.
C-a.ii	If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. *Textbox currently blank*	**QP3 and QP4. ODP conducts full reviews through the ODP QA&I Process on a 3-year cycle for Supports Coordination Organizations (SCO) and providers.**	This language is being revised to align with the ID/A waivers.
C-b.i-ii	**Methods for Remediation/Fixing Individual Problems** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. BAS reviews findings of the documentation review annually. If findings from discovery activities indicate a provider does not meet provider standards, BAS will contact the provider for more information to assess whether the provider meets standards. If a provider does not meet provider standards, BAS will give the provider 30 days to remediate the reason for ineligibility. BAS will provide technical assistance and training to the provider during this time to prevent disenrollment. BAS will advise Supports Coordinators that the provider may be disenrolled and that a) participants may need to find new providers and b) Supports Coordinators must not include the provider in new ISPs during the 30 day period. If the provider is a Supports Coordination agency, BAS will notify participants that the provider may be disenrolled and that participants may need to find new providers. If the provider does not meet provider standards after 30 days, BAS will disenroll	Methods for Remediation/Fixing Individual Problems Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. ~~BAS reviews findings of the documentation review annually.~~ ~~If findings from discovery activities indicate a provider does not meet provider standards, BAS will contact the provider for more information to assess whether the provider meets standards. If a provider does not meet provider standards, BAS will give the provider 30 days to remediate the reason for ineligibility. BAS will provide technical assistance and training to the provider during this time to prevent disenrollment. BAS will advise Supports Coordinators that the provider may be disenrolled and that a) participants may need to find new providers and b) Supports Coordinators must not include the provider in new ISPs during the 30 day period. If the provider is a Supports Coordination agency, BAS will notify participants that the provider may be disenrolled and that participants may need to find new providers. If the provider does not meet provider standards after 30 days, BAS will disenroll the~~	This language is being revised to align with the ID/A waivers.

	the provider and notify Supports Coordinators that participants will need to identify a new provider. The Supports Coordinator will notify the participant that a new provider is necessary. If the provider is a Supports Coordination agency, BAS will notify participants and assist them in choosing new Supports Coordination agencies. BAS will send a notice of action to the provider to let the provider know that it can appeal the disenrollment decision to the DPW Bureau of Hearings and Appeals. BAS may require the provider to refund some or all of the payments it has received. If BAS identifies provider staff that do not meet provider standards, BAS will require the provider to specify whether it will assign different staff or perform tasks necessary for the staff to meet provider requirements (e.g., conduct a criminal background check or complete BAS-required training). Any tasks to enable staff to meet provider requirements must be completed within 30 days. BAS will provide technical assistance and training to the provider during this time. If the provider attempts to help the staff person meet qualifications, BAS will follow up with the provider after 30 days to ensure that the provider's attempts to have staff meet qualifications have been completed. BAS also will notify the Supports Coordinator when provider staff does not meet provider standards. The Supports Coordinator will inform the participant that the provider staff did not meet qualifications and the planned corrective action. The Supports Coordinator will remind the participant that he or she may choose a different provider for the service. If the provider staff person that does not meet standards is a Supports Coordinator, BAS will inform the participant and remind the participant that he or she may choose a different provider. Following the process described in the Financial Accountability assurance, BAS may require the provider to refund some or all of the payments received for services provided by this staff person. **Remediation-related Data Aggregation and Analysis (including trend identification)** **Frequency of data aggregation and analysis** *(check each that applies)*: X **Quarterly**	~~provider and notify Supports Coordinators that participants will need to identify a new provider. The Supports Coordinator will notify the participant that a new provider is necessary. If the provider is a Supports Coordination agency, BAS will notify participants and assist them in choosing new Supports Coordination agencies. BAS will send a notice of action to the provider to let the provider know that it can appeal the disenrollment decision to the DPW Bureau of Hearings and Appeals. BAS may require the provider to refund some or all of the payments it has received.~~ ~~If BAS identifies provider staff that do not meet provider standards, BAS will require the provider to specify whether it will assign different staff or perform tasks necessary for the staff to meet provider requirements (e.g., conduct a criminal background check or complete BAS-required training). Any tasks to enable staff to meet provider requirements must be completed within 30 days. BAS will provide technical assistance and training to the provider during this time. If the provider attempts to help the staff person meet qualifications, BAS will follow up with the provider after 30 days to ensure that the provider's attempts to have staff meet qualifications have been completed.~~ ~~BAS also will notify the Supports Coordinator when provider staff does not meet provider standards. The Supports Coordinator will inform the participant that the provider staff did not meet qualifications and the planned corrective action. The Supports Coordinator will remind the participant that he or she may choose a different provider for the service. If the provider staff person that does not meet standards is a Supports Coordinator, BAS will inform the participant and remind the participant that he or she may choose a different provider. Following the process described in the Financial Accountability assurance, BAS may require the provider to refund some or all of the payments received for services provided by this staff person.~~ ~~If findings from discovery activities indicate a provider does not meet provider standards, BAS will contact the provider for more information to assess whether the provider meets standards. If a provider does not meet provider standards, BAS will give the provider 30 days to remediate the reason for ineligibility. BAS will provide technical assistance and training to the provider during this time to prevent disenrollment. BAS will advise Supports~~	

		~~Coordinators that the provider may be disenrolled and that a) participants may need to find new providers and b) Supports Coordinators must not include the provider in new ISPs during the 30 day period. If the provider is a Supports Coordination agency, BAS will notify participants that the provider may be disenrolled and that participants may need to find new providers. If the provider does not meet provider standards after 30 days, BAS will disenroll the provider and notify Supports Coordinators that participants will need to identify a new provider. The Supports Coordinator will notify the participant that a new provider is necessary. If the provider is a Supports Coordination agency, BAS will notify participants and assist them in choosing new Supports Coordination agencies. BAS will send a notice of action to the provider to let the provider know that it can appeal the disenrollment decision to the DPW Bureau of Hearings and Appeals. BAS may require the provider to refund some or all of the payments it has received.~~ ~~If BAS identifies provider staff that do not meet provider standards, BAS will require the provider to specify whether it will assign different staff or perform tasks necessary for the staff to meet provider requirements (e.g., conduct a criminal background check or complete BAS-required training). Any tasks to enable staff to meet provider requirements must be completed within 30 days. BAS will provide technical assistance and training to the provider during this time. If the provider attempts to help the staff person meet qualifications, BAS will follow up with the provider after 30 days to ensure that the provider's attempts to have staff meet qualifications have been completed.~~ ~~BAS also will notify the Supports Coordinator when provider staff does not meet provider standards. The Supports Coordinator will inform the participant that the provider staff did not meet qualifications and the planned corrective action. The Supports Coordinator will remind the participant that he or she may choose a different provider for the service. If the provider staff person that does not meet standards is a Supports Coordinator, BAS will inform the participant and remind the participant that he or she may choose a different provider. Following the process described in the Financial Accountability assurance, BAS may require the provider to refund some or all of the payments received for services provided by this staff person.~~	

		QP2 and QP3: Through the QA&I Process, ODP conducts full reviews of 100% of SCOs and providers on a 3-year cycle using the standardized monitoring tools developed by ODP. If the required age, education, experience, criminal background check and staff training requirements are not documented in the provider's records, ODP will notify the provider and the provider must locate missing documentation or ensure that requirements are met within 30 days. The remediation for this process will occur as outlined in the ODP established corrective action process. Remediation-related Data Aggregation and Analysis (including trend identification) Frequency of data aggregation and analysis (check each that applies): Specify: X Quarterly **X Annually**	
Appendix D			
D-1-d	The Supports Coordinator shall complete the following activities as needed during the comprehensive annual review of the ISP according to the timelines specified in 55 Pa. Code §51.29 (SCA requirements for Adult Autism Waiver): (1) Coordinate information gathering and assessment activities which includes the administration of assessments (2) Collaborate with the participant and persons designated by the participant to coordinate a date, time and location for the annual review ISP meeting that is convenient for the participant. (3) Distribute invitations to ISP team members before the annual review ISP meeting. (4) Facilitate the ISP meeting. (5) Obtain signatures from the participant, persons designated by the participant, and providers responsible for the plan's implementation to document their agreement with the ISP. (6) Submit the ISP to BAS for approval and authorization (7) If BAS requests revision of the ISP, resubmit the amended ISP for approval and authorization (8) Distribute the ISP to the ISP team members, including the participant and representative (if applicable), who do not have access to HCSIS, in a manner chosen by the team member.	The Supports Coordinator shall complete the following activities as needed during the comprehensive annual review of the ISP according to the **following** timelines ~~specified in 55 Pa. Code §51.29 (SCA requirements for Adult Autism Waiver)~~: (1) Coordinate information gathering and assessment activities which includes the administration of assessments (2) Collaborate with the participant and persons designated by the participant to coordinate a date, time and location for the annual review ISP meeting that is convenient for the participant. (3) Distribute invitations to ISP team members before the annual review ISP meeting. (4) Facilitate the ISP meeting. (5) Obtain signatures from the participant, persons designated by the participant, and providers responsible for the plan's implementation to document their agreement with the ISP. (6) Submit the ISP to ~~BAS~~ **ODP** for approval and authorization (7) If ~~BAS~~ **ODP** requests revision of the ISP, resubmit the amended ISP for approval and authorization (8) Distribute the ISP to the ISP team members, including the participant and representative (if applicable), who do not have access to HCSIS, in a manner chosen by the team member.	ODP removed the reference to 55 Pa. Code Chapter 51.

	(B) The Types of Assessments That Are Conducted To Support The ISP Process, Including Securing Information About Participant Needs, Preferences And Goals, And Health Status The ISP form also includes identifying information about the participant and a summary of all the assessments, outcomes and actions needed for implementation of the ISP. Information gathered for purposes of completing the ISP includes information on the participant's physical development, communication styles, learning styles, educational background, social/emotional information, medical information, personality traits, environmental influences, interactions, preferences, relationships that impact the participant's quality of life, and an evaluation of the risks to the participant's health and welfare. The ISP also includes who will provide services, the frequency of services, who is responsible for implementing different aspects of the plan, how services will be monitored for consistency with the ISP, and how both waiver and non-waiver services will be coordinated. The ISP makes clear who is responsible for addressing the participant's other needs, including those related to accessing health care, behavioral support, financial support, and risk mitigation to prevent or reduce the likelihood of negative health and welfare events.	(B) The Types of Assessments That Are Conducted To Support The ISP Process, Including Securing Information About Participant Needs, Preferences And Goals, And Health Status The ISP form also includes identifying information about the participant and a summary of all the assessments, outcomes and actions needed for implementation of the ISP. Information gathered for purposes of completing the ISP includes information on the participant's physical development, communication styles, learning styles, educational background, social/emotional information, medical information **(including any needs identified in a health risk screening tool when applicable)**, personality traits, environmental influences, interactions, preferences, relationships that impact the participant's quality of life, and an evaluation of the risks to the participant's health and welfare. The ISP also includes who will provide services, the frequency of services, who is responsible for implementing different aspects of the plan, how services will be monitored for consistency with the ISP, and how both waiver and non-waiver services will be coordinated. The ISP makes clear who is responsible for addressing the participant's other needs, including those related to accessing health care, behavioral support, financial support, and risk mitigation to prevent or reduce the likelihood of negative health and welfare events.	To promote health, wellness and safety, ODP is exploring the use of health risk screening tools. This proposed clarification would ensure that ISPs align with any such tool utilized.
Appendix D: Quality Improvement: Service Plan			
D-a.i.a	**Performance Measure SP1: Number and percent of participants who have all documented needs and personal goals addressed in the ISP through waiver funded services or other non-waiver supports. Numerator = Number of participants who have all needs and personal goals addressed in the ISP through waiver funded services or other non-waiver supports. Denominator = Number of participants reviewed.** **Data Source** (Select one): **Other** If 'Other' is selected, specify **Review of ISPs**	Performance Measure SP1: Number and percent of participants who have all ~~documented~~ **assessed** needs and personal goals addressed in the ~~ISP~~ **service plan** ~~through waiver funded services or other non-waiver supports~~. Numerator = Number of participants who have all **assessed** needs and personal goals addressed in the ~~ISP~~ **service plan** through waiver funded services or other ~~non-waiver supports~~ **funding sources or through natural supports**. Denominator = Number of participants reviewed. Data Source Other If 'Other' is selected, specify: ~~Review of ISPs~~ **Participant Record Review**	Changes are being made to align with BCS management of the service plan performance measures.

D-a.i.c	**Performance Measure SP2: Number and percent of participants whose service plans are updated/revised at least annually and in response to a change in need.** **Numerator = Number of participants whose service plans are updated/revised at least annually and in response to a change in need.** **Denominator = Number of participants reviewed**. **Data Source (Select one): Other** If 'Other' is selected, specify: **Annual Monitoring** **Frequency of data collection/generation** *(check each that applies):* Continuously and Ongoing	Performance Measure SP2: Number and percent of participants whose service plans are updated/revised at least annually ~~and in response to a change in need~~. Numerator = Number of participants **reviewed** whose service plans are updated/revised at least annually ~~and in response to a change in need~~. Denominator = Number of participants reviewed. Data Source (Select one): Other If 'Other' is selected, specify: ~~Annual Monitoring~~ **Participant Record Review** Frequency of data collection/generation (check each that applies): ~~Continuously and Ongoing~~ **Annually**	ODP is separating out the review and measurement of service plans updated or revised at least annually from the review and measurement of service plans updated in response to a change in need.
N/A	*This performance measure is not currently in the waiver*	**Performance Measure SP3: Number and percent of participants whose needs changed and whose service plans were revised accordingly. Numerator = Number of participants reviewed whose needs changed and whose service plans were revised accordingly. Denominator = number of participants reviewed whose needs changed.** Data Source (Select one): **X Other** If 'Other' is selected, specify: **Participant Record Review** Responsible Party for data collection/generation: **State Medicaid Agency** Frequency of data collection/generation: **X Annually** Sampling Approach: **X Less than 100% Review** Representative Sample **Confidence Interval = 90%+/-10%** Responsible Party for data aggregation and analysis **State Medicaid Agency**	ODP is separating out the review and measurement of service plans updated or revised at least annually from the review and measurement of service plans updated or revised in response to a change in need.

		Frequency of data aggregation and analysis: **X Annually**	
D-a.i.d	Performance Measure SP3: Number and percent of participants whose services were delivered in the type, scope, amount, duration and frequency specified in the service plan. Numerator = Number of participants whose services were delivered in the type, scope, amount, duration and frequency specified in the service plan. Denominator = Number of participants reviewed. **Data Source** (Select one): **Other** If 'Other' is selected, specify: **Home and Community Services Information System (HCSIS)**	Performance Measure ~~SP3~~ **SP4**: Number and percent of participants whose services were delivered in the type, scope, amount, duration and frequency specified in the service plan. Numerator = Number of participants whose services were delivered in the type, scope, amount, duration and frequency specified in the service plan. Denominator = Number of participants reviewed. Data Source (Select one): Other If 'Other' is selected, specify: ~~Home and Community Services Information System (HCSIS)~~ **Participant Record Review**	ODP updated the performance measure numbering and changed the data source to align with the ODP QA&I process.
D-a.i.e	Performance Measure SP4: Number and percent of participants for whom choices among waiver services and providers is documented. Numerator =Number of participants for whom choices among waiver services and providers is documented. Denominator = Number of participants reviewed. **Data Source** (Select one): **Record reviews, on-site** If 'Other' is selected, specify: **Participant record reviews**	Performance Measure ~~SP4~~ **SP5**: Number and percent of participants ~~for whom choices~~ **whose records document choice between and** among waiver services and providers ~~is documented~~ **was offered to the participant/family**. Numerator =Number of participants ~~for whom choices~~ **whose records document choice between and** among waiver services and providers i~~s documented~~ **was offered to the participant/family**. Denominator = Number of participants reviewed. Data Source (Select one): ~~Record reviews, on-site~~ **Other** If 'Other' is selected, specify: Participant record reviews	ODP revised the language to align with the ID/A waivers.
D-a.ii	If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. An individual is not able to receive waiver-funded services that are not in his or her ISP. As described in Appendix I, PROMISe and HCSIS system edits limit payments to waiver services specified in the participant's ISP. BAS staff review all ISPs before provision of services, and approve or request revisions to ISPs based on the ISP, Supports Coordinator notes, copies of the	If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. ~~An individual is not able to receive waiver-funded services that are not in his or her ISP. As described in Appendix I, PROMISe and HCSIS system edits limit payments to waiver services specified in the participant's ISP.~~ ~~BAS staff review all ISPs before provision of services, and approve or request revisions to ISPs based on the ISP, Supports Coordinator notes, copies of the~~	

	needs assessments specified in Appendix D-1-d(b), and copies of the forms specified in Appendix B-7-a to document the participant received a choice between waiver and institutional services and a choice among waiver providers. Supports Coordinators monitor whether services were actually provided as part of the ISP monitoring described in Appendix D-2-a. Supports Coordinators must contact the participant at least each month and visit the participant in-person at least each quarter. Within each year, at least one visit must occur in the participant's home. At least one visit must occur in a location outside the home where a participant receives services, if the services are furnished outside the home. The monitoring includes assessing the extent to which the participant is receiving waiver services and non-waiver services in the amount, duration, and frequency specified in his or her ISP. Supports Coordinators indicate in their notes in HCSIS if information suggests 1) a participant's utilization of waiver services is different from what has been authorized; and/or 2) a participant is not able to access non-waiver services as specified in the ISP. In addition, BAS staff interview a sample of participants, and their provider staff, to assess the quality of services. BAS developed a standard template for these interviews, which includes questions regarding unmet needs and goals; the service planning process; participant choice of provider; participant choice between waiver and institutional services; and the amount, scope, and frequency of services provided. BAS staff also review provider and Supports Coordinator documentation for these participants to identify indications of unmet needs and goals and of under-or over-utilization. The records include assessment instruments; the forms identified in Appendix B-7; Supports Coordinator notes; ISPs; critical incident reports; and providers' records of service delivery.	~~needs assessments specified in Appendix D-1-d(b), and copies of the forms specified in Appendix B-7-a to document the participant received a choice between waiver and institutional services and a choice among waiver providers.~~ ~~Supports Coordinators monitor whether services were actually provided as part of the ISP monitoring described in Appendix D-2-a. Supports Coordinators must contact the participant at least each month and visit the participant in-person at least each quarter. Within each year, at least one visit must occur in the participant's home. At least one visit must occur in a location outside the home where a participant receives services, if the services are furnished outside the home. The monitoring includes assessing the extent to which the participant is receiving waiver services and non-waiver services in the amount, duration, and frequency specified in his or her ISP. Supports Coordinators indicate in their notes in HCSIS if information suggests 1) a participant's utilization of waiver services is different from what has been authorized; and/or 2) a participant is not able to access non-waiver services as specified in the ISP.~~ ~~In addition, BAS staff interview a sample of participants, and their provider staff, to assess the quality of services. BAS developed a standard template for these interviews, which includes questions regarding unmet needs and goals; the service planning process; participant choice of provider; participant choice between waiver and institutional services; and the amount, scope, and frequency of services provided.~~ ~~BAS staff also review provider and Supports Coordinator documentation for these participants to identify indications of unmet needs and goals and of under-or over-utilization. The records include assessment instruments; the forms identified in Appendix B-7; Supports Coordinator notes; ISPs; critical incident reports; and providers' records of service delivery.~~ **For Performance Measures SP1, SP2, SP4, and SP5, ODP staff review a proportionate, representative random sample of waiver participant records annually.**	ODP revised this language to align with the ID/A waivers.

		For Performance Measure SP3, a subset of the proportionate, representative random sample of waiver records of participants whose needs changed is reviewed.	
D-b.i-ii	**Methods for Remediation/Fixing Individual Problems** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. After reviewing each service plan, BAS directs the Supports Coordinator to revise the ISP if 1) the ISP does not address all identified needs or goals; 2) it appears the Supports Coordinator did not follow the service planning process; or 3) there is insufficient documentation that the participant exercised his or her rights to choose among service providers and/or between waiver and institutional services. BAS may contact the participant and representative (if applicable) to investigate the situation. The Supports Coordinator must revise the ISP, reconvening the planning team and/or conducting assessments if necessary, and send the revised ISP to BAS for review within 7 days of the date it was returned to the Supports Coordinator for revision. If an individual's ISP does not address all of an individual's needs, and services appear inadequate to assure the participant's health and welfare, BAS staff will require the Supports Coordinator to reconvene the planning team within 30 days to change the ISP. Similarly, if the service planning process was not followed and may affect participant's health and welfare, BAS staff will require the Supports Coordinator to reconvene the planning team within 30 days to review the ISP. If a Supports Coordinator finds that a participant is not receiving the services authorized in his or her ISP, he or she will contact the provider(s), the participant and representative (if applicable) to identify the reason services were not delivered and address reasons for underutilization. The Supports Coordinator may revise the ISP if the participant at any time wishes to change providers. The Supports Coordinator may re-convene the ISP team to address underutilization. For example, if the participant finds he or she does not need	Methods for Remediation/Fixing Individual Problems Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. ~~After reviewing each service plan, BAS directs the Supports Coordinator to revise the ISP if 1) the ISP does not address all identified needs or goals; 2) it appears the Supports Coordinator did not follow the service planning process; or 3) there is insufficient documentation that the participant exercised his or her rights to choose among service providers and/or between waiver and institutional services. BAS may contact the participant and representative (if applicable) to investigate the situation. The Supports Coordinator must revise the ISP, reconvening the planning team and/or conducting assessments if necessary, and send the revised ISP to BAS for review within 7 days of the date it was returned to the Supports Coordinator for revision.~~ ~~If an individual's ISP does not address all of an individual's needs, and services appear inadequate to assure the participant's health and welfare, BAS staff will require the Supports Coordinator to reconvene the planning team within 30 days to change the ISP. Similarly, if the service planning process was not followed and may affect participant's health and welfare, BAS staff will require the Supports Coordinator to reconvene the planning team within 30 days to review the ISP.~~ ~~If a Supports Coordinator finds that a participant is not receiving the services authorized in his or her ISP, he or she will contact the provider(s), the participant and representative (if applicable) to identify the reason services were not delivered and address reasons for underutilization. The Supports Coordinator may revise the ISP if the participant at any time wishes to change providers. The Supports Coordinator may re-convene the ISP team to address underutilization. For example, if the participant finds he or she does not need~~	ODP revised this language to align with the ID/A waivers.

	the amount of services in the ISP, the Supports Coordinator and the ISP team may assess whether the amount of services in the ISP should be reduced. At any point, if BAS determines that an individual was not able to freely exercise the right to choose 1) between waiver and institutional services, or 2) among service providers; BAS will contact the participant to ensure they are aware of their right to choose between waiver and institutional services or among service providers. BAS may assist the individual in finding a new Supports Coordinator or Supports Coordination Agency if necessary or desired. If the person prefers institutional services, BAS must identify available institutions for the individual. **ii. Remediation Data Aggregation** **Frequency of data aggregation and analysis** *(check each that applies)*: **Quarterly**	~~the amount of services in the ISP, the Supports Coordinator and the ISP team may assess whether the amount of services in the ISP should be reduced.~~ ~~At any point, if BAS determines that an individual was not able to freely exercise the right to choose 1) between waiver and institutional services, or 2) among service providers; BAS will contact the participant to ensure they are aware of their right to choose between waiver and institutional services or among service providers. BAS may assist the individual in finding a new Supports Coordinator or Supports Coordination Agency if necessary or desired. If the person prefers institutional services, BAS must identify available institutions for the individual.~~ **SP1. Number and percent of participants who have all assessed needs and personal goals addressed in the service plan through waiver funded services or services funded through other funding sources or through natural supports. ODP reviews a sample of records to determine if participants have all assessed needs and personal goals addressed in their service plans through waiver funded services or services funded through other funding sources or through natural supports. If a participant's plan does not contain evidence that all assessed needs and personal goals have been reviewed and/or addressed by the participant and his/her team, ODP will work with the SCO to ensure that the service plan is revised to support the identified assessed needs and personal goals. The SCO will provide ODP with the service plan approval date that reflects the changes made to the service plan that correct the identified noncompliance. Remediation by the SCO is expected within 30 days of notification.** **SP2. Number and percent of participants whose service plans are updated or revised at least annually. If there is no evidence in the record that the service plan was completed, approved, and services authorized by the Annual Review Update Date, ODP will work with the SCO to ensure the service plan is completed within 30 days of notification.** **SP3. Number and percent of participants whose needs changed and whose service plans were revised accordingly. ODP reviews a sample of records to determine if service plans were revised when a change in need was identified**	

		that required a change in services. If the service plan is not revised, ODP will inform the Supports Coordinator (SC) that revisions to the service plan must be made. Remediation is expected to occur within 21 days of notification. **SP4. Number and percent of participants whose services and supports were delivered in the type, scope, amount, duration and frequency specified in the service plan. Using the sample of waiver participants, ODP reviews the individual monitoring tool completed by the SCO and claims for services delivered to ensure that services have been delivered in the type, scope, amount, duration and frequency specified in the service plan. If services were not delivered as specified in the participant's service plan, the SCO will provide documentation to ODP of the resolution. Resolution can include but is not limited to change in service provider, resumption of services at required frequency, team meetings, or changes in frequency and duration of a service. Remediation is expected to occur within 21 days of notification.** **SP5. Number and percent of participants whose records document choice between and among waiver services and providers was offered to the participant/family. If there was no documentation that choice between and among services and providers was offered, ODP will direct the SC to follow-up with the individual and his or her family to provide the necessary information. The SC will use the service plan Signature Form to document that choice between and among services and service providers was offered as well as to document the date follow-up occurred. Remediation actions and submission of documentation to ODP should occur within 30 days of notification.** ii. Remediation Data Aggregation Frequency of data aggregation and analysis *(check each that applies):* ~~Quarterly~~ **X Annually**	
Appendix G			
G-1-b	**State Critical Event or Incident Reporting Requirements**. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws,	State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws,	ODP revised the language to align with the Chapter 6100 regulations.

	regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). BAS articulated the incident management policy described below in a provider manual for all providers and a manual specifically for supports coordinators. All Adult Autism Waiver providers must follow this policy. Types of incidents that must be reported: Incidents to be reported within 24 hours Most incident categories are reported using a standardized incident report that is comprised of two components, the first section and the final section. The first section must be submitted within 24 hours of the occurrence or discovery of the incident or within 72 hours of the occurrence or discovery of a medication administration error incident. The first section of the incident report includes individual and provider demographics, incident categorization, actions taken to protect the health and safety of the individual, and a description of the incident. The final section of the incident report must be submitted within 30 days of the incident's recognition or discovery, and must contain all of the information from the first section as well as additional specific information relevant to the incident. If the provider agency determines it will not be able to meet the 30-day reporting timeframes for completion of the final section, notification of an extension is to be made to BAS staff prior to the expiration of the 30-day period. Providers must submit all incidents within the Enterprise Incident Management (EIM) system. EIM enables prompt notification of BAS and the Supports Coordinator. If EIM is unavailable, providers must complete and e-mail incident reports using a password-protected Excel form developed by BAS. Providers must e-mail the password separately to protect participant confidentiality. The forms were designed to collect the exact data collected in EIM. In such cases, BAS staff will notify supports coordinators of critical incidents for the people they serve via telephone and/or e-mail of password protected files.	regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). ~~BAS articulated the incident management policy described below in a provider manual for all providers and a manual specifically for supports coordinators. All Adult Autism Waiver providers must follow this policy~~. ~~Types of incidents that must be reported:~~ ~~Incidents to be reported within 24 hours~~ ~~Most incident categories are reported using a standardized incident report that is comprised of two components, the first section and the final section. The first section must be submitted within 24 hours of the occurrence or discovery of the incident or within 72 hours of the occurrence or discovery of a medication administration error incident. The first section of the incident report includes individual and provider demographics, incident categorization, actions taken to protect the health and safety of the individual, and a description of the incident. The final section of the incident report must be submitted within 30 days of the incident's recognition or discovery, and must contain all of the information from the first section as well as additional specific information relevant to the incident. If the provider agency determines it will not be able to meet the 30-day reporting timeframes for completion of the final section, notification of an extension is to be made to BAS staff prior to the expiration of the 30-day period.~~ ~~Providers must submit all incidents within the Enterprise Incident Management (EIM) system. EIM enables prompt notification of BAS and the Supports Coordinator.~~ ~~If EIM is unavailable, providers must complete and e-mail incident reports using a password-protected Excel form developed by BAS. Providers must e-mail the password separately to protect participant confidentiality. The forms were designed to collect the exact data collected in EIM. In such cases, BAS staff will notify supports coordinators of critical incidents for the people they serve via telephone and/or e-mail of password protected files.~~	

	In Appendix G-1-d, BAS specifies the types of incidents that must be investigated. The entity that reports an incident – whether a provider, a SC agency, or BAS – must identify a certified investigator to conduct required investigations promptly. A certified investigator is a person who has been trained and received a certificate in investigation from ODP. All enrolled providers are required to either have a certified investigator on staff or contract with a certified investigator. Certified investigators are responsible to investigate incidents as per their standard training, and to complete an Incident Report with a summary of their investigation findings. Corrective action for the incident must address any investigation findings. The following are categories of incidents to be reported within 24 hours using a standardized incident report: 1. Abuse - The allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Abuse is reported from the victim's perspective, not from the perspective of the person committing the abuse. (i) Physical abuse – An intentional physical act by staff or other person which causes or may cause physical injury to an individual, such as striking or kicking, applying noxious or potentially harmful substances or conditions to an individual. (ii) Psychological abuse– An act, other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual. (iii)Sexual abuse– An act or attempted acts such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Any sexual contact between a staff person and an individual is abuse. (iv)Verbal abuse – A verbalization that inflicts or may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual. (v) Improper or unauthorized use of restraint – A restraint not approved in the ISP or one that is not a part of an agency's emergency restraint procedure is considered unauthorized. A restraint that is intentionally applied incorrectly is considered an improper use of restraint. 2. Death – All deaths are reportable.	~~In Appendix G-1-d, BAS specifies the types of incidents that must be investigated. The entity that reports an incident – whether a provider, a SC agency, or BAS – must identify a certified investigator to conduct required investigations promptly. A certified investigator is a person who has been trained and received a certificate in investigation from ODP. All enrolled providers are required to either have a certified investigator on staff or contract with a certified investigator. Certified investigators are responsible to investigate incidents as per their standard training, and to complete an Incident Report with a summary of their investigation findings. Corrective action for the incident must address any investigation findings.~~ ~~The following are categories of incidents to be reported within 24 hours using a standardized incident report:~~ ~~1. Abuse - The allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Abuse is reported from the victim's perspective, not from the perspective of the person committing the abuse.~~ ~~(i) Physical abuse – An intentional physical act by staff or other person which causes or may cause physical injury to an individual, such as striking or kicking, applying noxious or potentially harmful substances or conditions to an individual.~~ ~~(ii) Psychological abuse– An act, other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.~~ ~~(iii)Sexual abuse– An act or attempted acts such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Any sexual contact between a staff person and an individual is abuse.~~ ~~(iv)Verbal abuse – A verbalization that inflicts or may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.~~ ~~(v) Improper or unauthorized use of restraint – A restraint not approved in the ISP or one that is not a part of an agency's emergency restraint procedure is considered unauthorized. A restraint that is intentionally applied incorrectly is considered an improper use of restraint.~~ ~~2. Death – All deaths are reportable.~~	

	3. Disease Reportable to the Department of Health – An occurrence of a disease on The Pennsylvania Department of Health List of Reportable Diseases. The current list can be found at the Department of Health's website, www.health.state.pa.us. An incident report is required only when the reportable disease is initially diagnosed. 4. Emergency closure – An unplanned situation that results in the closure of a home or program facility for one or more days. This category does not apply to individuals who reside in their own home or the home of a family member. (This may be reported as a site report, which is a report related to multiple participants receiving services at the same place.) 5. Emergency room visit – The use of a hospital emergency room. This includes situations that are clearly "emergencies" as well as those when an individual is directed to an emergency room in lieu of a visit to the Primary Care Physician (PCP) or as the result of a visit to the PCP. The use of an emergency room by an individual's PCP, in place of the physician's office, is not reportable. 6. Fire – A situation that requires the active involvement of fire personnel that is extinguishing a fire, clearing smoke from the premises, responding to a false alarm, and the like. Situations which require the evacuation of a facility in response to suspected or actual gas leaks and/or carbon monoxide alarms, or both, are reportable. Situations in which staff extinguish small fires without the involvement of fire personnel are reportable. This may be reported as a site report. 7. Hospitalization – An inpatient admission to an acute care facility for purposes of treatment. Scheduled treatment of medical conditions on an outpatient basis is not reportable. 8. Individual-to-individual abuse – An interaction between one individual receiving services and another individual receiving services resulting in an allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Individual-to-individual abuse is reported on from the victim's perspective, not on the person committing the abuse. 9. Injury requiring treatment beyond first aid – Any injury that requires the provision of medical treatment beyond that traditionally considered first aid. First aid includes assessing a condition, cleaning an injury, applying topical medications, applying a Band-Aid, and the like. Treatment beyond first aid	~~3. Disease Reportable to the Department of Health – An occurrence of a disease on The Pennsylvania Department of Health List of Reportable Diseases. The current list can be found at the Department of Health's website, www.health.state.pa.us. An incident report is required only when the reportable disease is initially diagnosed.~~ ~~4. Emergency closure – An unplanned situation that results in the closure of a home or program facility for one or more days. This category does not apply to individuals who reside in their own home or the home of a family member. (This may be reported as a site report, which is a report related to multiple participants receiving services at the same place.)~~ ~~5. Emergency room visit – The use of a hospital emergency room. This includes situations that are clearly "emergencies" as well as those when an individual is directed to an emergency room in lieu of a visit to the Primary Care Physician (PCP) or as the result of a visit to the PCP. The use of an emergency room by an individual's PCP, in place of the physician's office, is not reportable.~~ ~~6. Fire – A situation that requires the active involvement of fire personnel that is extinguishing a fire, clearing smoke from the premises, responding to a false alarm, and the like. Situations which require the evacuation of a facility in response to suspected or actual gas leaks and/or carbon monoxide alarms, or both, are reportable. Situations in which staff extinguish small fires without the involvement of fire personnel are reportable. This may be reported as a site report.~~ ~~7. Hospitalization – An inpatient admission to an acute care facility for purposes of treatment. Scheduled treatment of medical conditions on an outpatient basis is not reportable.~~ ~~8. Individual-to-individual abuse – An interaction between one individual receiving services and another individual receiving services resulting in an allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Individual-to-individual abuse is reported on from the victim's perspective, not on the person committing the abuse.~~ ~~9. Injury requiring treatment beyond first aid – Any injury that requires the provision of medical treatment beyond that traditionally considered first aid. First aid includes assessing a condition, cleaning an injury, applying topical medications, applying a Band-Aid, and the like. Treatment beyond first aid~~	

	includes but is not limited to lifesaving interventions such as CPR or use of the Heimlich maneuver, wound closure by a medical professional, casting or otherwise immobilizing a limb. Evaluation/assessment of an injury by emergency personnel in response to a "911" call is reportable even if the individual is not transported to an emergency room. 10.Law enforcement activity – The involvement of law enforcement personnel is reportable in the following situations: (i) An individual is charged with a crime or is the subject of a police investigation that may lead to criminal charges. (ii) An individual causes an event, such as pulling a fire alarm that requires active involvement of law enforcement personnel, even if the event will not lead to criminal charges. (iii)An individual is the victim of a crime, including crimes against the person or their property. (iv)A crime, such as vandalism or a break-in, that occurs at a provider site. This may be reported as a site report. (v) An on-duty employee or an employee who is volunteering during off duty time, who is charged with an offense, a crime or is the subject of an investigation while on duty or volunteering. This is reported as a site report. (vi)A volunteer who is charged with an offense, a crime or is the subject of an investigation resulting from actions or behaviors that occurred while volunteering. This is reported as a site report. (vii) A crisis intervention involving police/law enforcement personnel. (viii) A citation given to an agency staff person for a moving violation while operating an agency vehicle, or while transporting individuals in a private vehicle, is reported as a site report. 11.Missing person – A person is considered missing when they are out of contact with staff for more than 24 hours without prior arrangement or if they are in immediate jeopardy when missing for any period of time. A person may be considered in "immediate jeopardy" based on the person's personal history and may be considered "missing" before 24 hours elapse. Additionally, it is considered a reportable incident whenever the police are contacted about an individual and/or the police independently find and return the individual, or both, regardless of the amount of time the person was missing. 12.Misuse of funds– An intentional act or course of conduct, which results in the loss or misuse of an individual's money or personal property. Requiring an	~~includes but is not limited to lifesaving interventions such as CPR or use of the Heimlich maneuver, wound closure by a medical professional, casting or otherwise immobilizing a limb. Evaluation/assessment of an injury by emergency personnel in response to a "911" call is reportable even if the individual is not transported to an emergency room.~~ ~~10.Law enforcement activity – The involvement of law enforcement personnel is reportable in the following situations:~~ ~~(i) An individual is charged with a crime or is the subject of a police investigation that may lead to criminal charges.~~ ~~(ii) An individual causes an event, such as pulling a fire alarm that requires active involvement of law enforcement personnel, even if the event will not lead to criminal charges.~~ ~~(iii)An individual is the victim of a crime, including crimes against the person or their property.~~ ~~(iv)A crime, such as vandalism or a break-in, that occurs at a provider site. This may be reported as a site report.~~ ~~(v) An on-duty employee or an employee who is volunteering during off duty time, who is charged with an offense, a crime or is the subject of an investigation while on duty or volunteering. This is reported as a site report.~~ ~~(vi)A volunteer who is charged with an offense, a crime or is the subject of an investigation resulting from actions or behaviors that occurred while volunteering. This is reported as a site report.~~ ~~(vii) A crisis intervention involving police/law enforcement personnel.~~ ~~(viii) A citation given to an agency staff person for a moving violation while operating an agency vehicle, or while transporting individuals in a private vehicle, is reported as a site report.~~ ~~11.Missing person – A person is considered missing when they are out of contact with staff for more than 24 hours without prior arrangement or if they are in immediate jeopardy when missing for any period of time. A person may be considered in "immediate jeopardy" based on the person's personal history and may be considered "missing" before 24 hours elapse. Additionally, it is considered a reportable incident whenever the police are contacted about an individual and/or the police independently find and return the individual, or both, regardless of the amount of time the person was missing.~~ ~~12.Misuse of funds– An intentional act or course of conduct, which results in the loss or misuse of an individual's money or personal property. Requiring an~~	

	individual to pay for an item or service that is normally provided as part of the ISP is considered financial exploitation and is reportable as a misuse of funds. Requiring an individual to pay for items that are intended for use by several individuals is also considered financial exploitation. Individuals may voluntarily make joint purchases with other individuals of items that benefit the household. 13.Neglect – The failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law or regulation. This includes the failure to provide needed care such as shelter, food, clothing, personal hygiene, medical care, protection from health and safety hazards, attention and supervision, including leaving individuals unattended and other basic treatment and necessities needed for development of physical, intellectual and emotional capacity and well-being. This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm. 14.Psychiatric hospitalization – An inpatient admission to a psychiatric facility, including crisis facilities and the psychiatric departments of acute care hospitals, for the purpose of evaluation and/or treatment, or both, whether voluntary or involuntary. This includes admissions for "23 hour" observation and those for the review and/or adjustment, or both, of medications prescribed for the treatment of psychiatric symptoms or for the control of challenging behaviors. 15.Rights violation – An act which is intended to improperly restrict or deny the human or civil rights of an individual including those rights which are specifically mandated under applicable regulations. Examples include but are not limited to, the unauthorized removal of personal property, refusal of access to the telephone, privacy violations, and breach of confidentiality. This does not include restrictions that are imposed by court order or consistent with a waiver of licensing regulations. 16.Suicide attempt – The intentional and voluntary attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include suicidal threats. 17.Crisis Event – Atypical behavior for the participant that has escalated to the point where there is a risk of serious harm to self or others or damage to property exhibited in an environment that is not accommodating to the behavior and the behavior has not been responsive to minimal intervention	~~individual to pay for an item or service that is normally provided as part of the ISP is considered financial exploitation and is reportable as a misuse of funds. Requiring an individual to pay for items that are intended for use by several individuals is also considered financial exploitation. Individuals may voluntarily make joint purchases with other individuals of items that benefit the household.~~ ~~13.Neglect – The failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law or regulation. This includes the failure to provide needed care such as shelter, food, clothing, personal hygiene, medical care, protection from health and safety hazards, attention and supervision, including leaving individuals unattended and other basic treatment and necessities needed for development of physical, intellectual and emotional capacity and well-being. This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm.~~ ~~14.Psychiatric hospitalization – An inpatient admission to a psychiatric facility, including crisis facilities and the psychiatric departments of acute care hospitals, for the purpose of evaluation and/or treatment, or both, whether voluntary or involuntary. This includes admissions for "23 hour" observation and those for the review and/or adjustment, or both, of medications prescribed for the treatment of psychiatric symptoms or for the control of challenging behaviors.~~ ~~15.Rights violation – An act which is intended to improperly restrict or deny the human or civil rights of an individual including those rights which are specifically mandated under applicable regulations. Examples include but are not limited to, the unauthorized removal of personal property, refusal of access to the telephone, privacy violations, and breach of confidentiality. This does not include restrictions that are imposed by court order or consistent with a waiver of licensing regulations.~~ ~~16.Suicide attempt – The intentional and voluntary attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include suicidal threats.~~ ~~17.Crisis Event – Atypical behavior for the participant that has escalated to the point where there is a risk of serious harm to self or others or damage to property exhibited in an environment that is not accommodating to the behavior and the behavior has not been responsive to minimal intervention~~	

	and could result in law enforcement involvement, hospitalization of the participant or other undesired outcomes. 18.Restraints - Any physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or portion of the individual's body, including those that are approved as part of an ISP or those used on an emergency basis. Improper or unauthorized use of restraint is considered abuse and is to be reported under the abuse category. Incidents to be reported within 72 hours The following category of incidents must be reported within 72 hours of the recognition or discovery of the event: 1. Medication error – Any nonconforming practice with the Rights of Medication Administration" as described in the ODP Medication Administration Training Course. This includes omission, wrong dose, wrong time, wrong person, wrong medication, wrong route, wrong position, wrong technique/method and wrong form. Individuals and/or entities that must report incidents - Providers: Employees, contracted agents and volunteers of Adult Autism Waiver providers are to respond to events that are defined as an incident. When an incident is recognized or discovered by a provider, prompt action is to be taken to protect the individual's health, safety and rights. The responsibility for this protective action is assigned to the provider initial reporter and point person. The protection may include calling 911, escorting to medical care, separating the perpetrator, arranging for counseling and referring to a victim assistance program. Unless otherwise indicated in the individual support plan, the provider point person or designee is to inform the individual's family or representative within 24 hours, or within 72 hours for medication errors, of the occurrence of an incident and to also inform the family or representative of the outcome of any investigation.	~~and could result in law enforcement involvement, hospitalization of the participant or other undesired outcomes.~~ ~~18.Restraints - Any physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or portion of the individual's body, including those that are approved as part of an ISP or those used on an emergency basis. Improper or unauthorized use of restraint is considered abuse and is to be reported under the abuse category.~~ ~~Incidents to be reported within 72 hours~~ ~~The following category of incidents must be reported within 72 hours of the recognition or discovery of the event:~~ ~~1. Medication error – Any nonconforming practice with the Rights of Medication Administration" as described in the ODP Medication Administration Training Course. This includes omission, wrong dose, wrong time, wrong person, wrong medication, wrong route, wrong position, wrong technique/method and wrong form.~~ **ODP uses an electronic web-based reporting solution for incident reporting and management known as the Enterprise Incident Management (EIM) system. All provider entities and SCOs are considered reporting entities and use EIM to report incidents to ODP. The incident lifecycle contains an incident notification process (known as the first section submission), a formalized investigation if warranted, a final notification process (known as the final section submission), and an approval process (known as the closure of the incident). When an event occurs, or is alleged to have occurred, that is considered an incident per policy, the initial notification is made by the reporting entity (provider or SCO) by submitting the first section of the incident report to ODP within 24 hours of discovery or recognition. SCs receive an alert that an incident was filed for a participant receiving support coordination services through the SCO. 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 participant. Once the**	

	After taking all appropriate actions following an incident to protect the individual, the provider is to report all categories of incidents and complete an investigation as necessary whenever services or supports are: 1. Rendered at the provider's site; 2. Provided in a community environment, other than an individual's home, while the individual is the responsibility of an employee, contracted agent or volunteer; or 3. Provided in an individual's own home or the home of his family, while an employee, contracted agent or volunteer is providing services in the home. In addition, employees, contracted agents or volunteers of provider agencies are to report deaths, alleged abuse, or neglect when they become aware of such incidents regardless of where or when these incidents occur. If the death, alleged abuse or neglect occurred beyond the provider's responsibility as specified above (relating to providers) the provider is not to report the incident according to Appendix G-1-b, but instead should give notice of the incident to the individual's supports coordinator. - Individuals and families. Individuals and families are to notify the provider, when they feel it is appropriate, or their supports coordinator regarding any health and safety concerns they may have related to a service or support that they are receiving. If an individual or family member observes or suspects abuse, neglect or any inappropriate conduct, whether occurring in the home or out of the home, they should contact the provider or their supports coordinator, or both and they may also contact BAS directly at a toll-free number, 1-866-539-7689. The supports coordinator will either inform the involved provider of the incident or file an incident report. Once informed by the supports coordinator, the provider is subsequently responsible to take prompt action to protect the individual, complete an investigation as necessary and file an incident report. In the event of the death of an individual, the family is requested to notify the supports coordinator.	**first section is submitted, ODP will review the first section of the incident report to ensure that prompt action was taken to protect the participant's health, safety, and rights. If the actions taken are insufficient, ODP will contact the reporting entity and direct additional actions.** **All incidents are investigated to rule out or identify instances of abuse, neglect, or exploitation. In addition, certain categories of incidents are required to be investigated by an ODP certified investigator. These include incidents of abuse, neglect, misuse of funds, death and rights violations. Misuse of funds and rights violations are considered exploitation.** **Abuse is defined as an allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Abuse is reported on from the victim's perspective, not the person committing the abuse.** **-Physical abuse. An intentional physical act by staff or other person which causes or may cause physical injury to an individual, such as striking or kicking, as well as applying noxious or potentially harmful substances or conditions to an individual.** **-Psychological abuse. An act, other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.** **-Sexual abuse. An act or attempted acts such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Any sexual contact between a staff person and an individual is abuse.** **-Verbal abuse. A verbalization that inflicts or may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.** **-Improper or unauthorized use of restraint. A restraint not approved in the individual support plan or one that is not a part of an agency's emergency restraint procedure is considered unauthorized. A restraint that is intentionally applied incorrectly is considered an improper use of restraint.**	

	- Supports Coordinators The supports coordinator is to immediately notify the provider when an individual or family informs their supports coordinator that an event has occurred that can be defined as an incident and services or supports were: 1. Rendered at the provider's site; 2. Provided in a community environment, other than an individual's home, while the individual is the responsibility of an employee, contracted agent or volunteer; or 3. Provided in an individual's own home or the home of his family, while an employee, contracted agent or volunteer is providing services in the home. The provider is responsible for taking prompt action to protect the individual, completing an investigation as necessary and filing an incident report. When an individual or a family member informs the supports coordinator of an event that can be categorized as an incident and the provider is not responsible for reporting the incident as specified in items 1 – 3 above, the supports coordinator will take prompt action to protect the individual. The supports coordinator may need to employ the resources of law enforcement, area agency on aging, counselors or other protective service agencies to protect the individual. Once the individual's health and safety are assured the supports coordinator will report the incident to BAS using the incident reporting methods described below. The supports coordination agency will assign a certified investigator if necessary according to Appendix G-1-d. When the individual's supports coordinator is informed of the death of the individual, the supports coordinator will determine if a report has been filed by a provider. If a provider is not required to file the report, the supports coordinator will file an incident report. If a supports coordinator is informed that a provider suspects that abuse or neglect is occurring beyond the authority of the provider to investigate as specified in items 1 – 3 above, the supports coordinator is to take all available action to protect the health and safety of the individual. The supports	**Neglect is defined as the failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law or regulation. This includes the failure to provide needed care such as shelter, food, clothing, personal hygiene, medical care, protection from health and safety hazards, attention and supervision, including leaving individuals unattended and other basic treatment and necessities needed for development of physical, intellectual and emotional capacity and well-being. This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm.** **Exploitation is defined to include misuse of funds and rights violation.** **-Misuse of funds. An intentional act or course of conduct which results in the loss or misuse of an individual's money or personal property. Requiring an individual to pay for an item or service that is normally provided as part of the individual support plan is considered financial exploitation and is reportable as a misuse of funds. Requiring an individual to pay for items that are intended for use by several individuals is also considered financial exploitation. Individuals may voluntarily make joint purchases with other individuals of items that benefit the household.** **-Rights violation. An act which is intended to improperly restrict or deny the human or civil rights of an individual, including those rights which are specifically mandated under applicable regulations. Examples include the unauthorized removal of personal property, refusal of access to the telephone, privacy violations and breach of confidentiality. This does not include restrictions that are imposed by court order or consistent with a waiver of licensing regulations.** **As part of the investigation, an investigator must take his or her 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.**	

	coordinator may need to employ the resources of law enforcement, area agency on aging, counselors or other protective service agencies to protect the individual. Once the individual's health and safety are assured the supports coordinator will report the incident to BAS using the incident reporting methods described below and the supports coordination agency will assign a certified investigator if necessary according to Appendix G-1-d. - Bureau of Autism Services In some circumstances, BAS staff may be required to report incidents. BAS staff are to report deaths and incidents of alleged abuse or neglect in circumstances when the process for reporting or investigating incidents, described in this waiver document, for providers or support coordination entities compromises objectivity. Incident Reporting Methods The primary method used to report incidents is EIM as described above. If EIM functionality is unavailable, the methods for reporting an incident are by fax or an e-mail to BAS of the password-protected incident management forms described above. All providers must also comply with the notification requirements of 35 P.S. §§ 10225.101 -10225.5102 (Older Adults Protective Services Act) and 35 P.S. §§ 10210.101-10210.704 (Adult Protective Services Act).	**An incident report is considered finalized when the reporting entity submits the final section of the incident report to ODP. Where appropriate, the final section of the incident report 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 is unable to finalize the incident report within 30 days due to circumstances beyond its control, the reporting entity shall notify ODP that an extension is necessary and provide the reason for the extension. When the need for an 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.** **After the reporting entity finalizes an incident report, ODP performs a review of the incident report within 30 days from the date of finalization. This review ensures that the incident was managed effectively and according to policy and that the investigation determination is supported by evidence, corrective actions are appropriate, planned, and prevent reoccurrence, and other pertinent information is included as necessary.** **In addition to reporting incidents to ODP, Pennsylvania also has protective service laws in place for adults with disabilities (ages 18-59) and older adults (ages 60 and over). All provider entities are mandated by law to report incidents of abuse, neglect, exploitation, and suspicious death to the appropriate protective services agencies.** **Below is a listing of the types of incidents that require reporting within 24 hours of occurrence or discovery:** **(1) Death.** **(2) A physical act by an individual in an attempt to commit suicide.** **(3) Inpatient admission to a hospital.**	

		(4) Abuse, including abuse to an individual by another individual. **(5) Neglect.** **(6) Exploitation.** **(7) An individual who is missing for more than 24 hours or who could be in jeopardy if missing for any period of time.** **(8) Law enforcement activity that occurred during the provision of an HCBS or for which an individual is the subject of a law enforcement investigation that may lead to criminal charges against the individual.** **(9) Injury requiring treatment beyond first aid.** **(10) Fire requiring the services of the fire department not including responses to false alarms.** **(11) Emergency closure.** **(12) A violation of individual rights.** **(13) Theft or misuse of individual funds.** **(14) Crisis Event.** **The following types of incidents require reporting within 72 hours of occurrence or discovery:** **(1) Use of a restraint.** **(2) A medication error as specified in § 6100.466 (relating to medication errors), if the medication was ordered by a health care practitioner.**	

		The following types of incidents require a formalized investigation to be completed by a Department-certified incident investigator: **(1) Death that occurs during the provision of a service.** **(2) Inpatient admission to a hospital as a result of an accidental or unexplained injury or an injury caused by a staff person, another individual or during the use of a restraint.** **(3) Abuse, including abuse to an individual by another individual.** **(4) Neglect.** **(5) Exploitation.** **(6) An injury requiring treatment beyond first aid as a result of an accidental or unexplained injury or an injury caused by a staff person, another individual or during the use of a restraint.** **(7) Theft or misuse of individual funds.** **(8) A violation of individual rights.** **If EIM is unavailable, providers must complete and e-mail incident reports using a password-protected Excel form developed by ODP. Providers must e-mail the password separately to protect participant confidentiality. The forms were designed to collect the exact data collected in EIM. In such cases, ODP staff will notify SCs of critical incidents for the participants they serve via telephone and/or e-mail of password protected files.** Individuals and/or entities that must report incidents - Providers: Employees, contracted agents and volunteers of Adult Autism Waiver providers are to respond to events that are defined as an incident. When an incident is recognized or discovered by a provider, prompt action is to be taken	

		to protect the individual's health, safety and rights. The responsibility for this protective action is assigned to the provider initial reporter and point person. The protection may include calling 911, escorting to medical care, separating the perpetrator, arranging for counseling and referring to a victim assistance program. Unless otherwise indicated in the individual support plan, the provider point person or designee is to inform the individual's family or representative within 24 hours, or within 72 hours for medication errors, of the occurrence of an incident and to also inform the family or representative of the outcome of any investigation. After taking all appropriate actions following an incident to protect the individual, the provider is to report all categories of incidents and complete an investigation as necessary whenever services or supports are: 1. Rendered at the provider's site; 2. Provided in a community environment, other than an individual's home, while the individual is the responsibility of an employee, contracted agent or volunteer; or 3. Provided in an individual's own home or the home of his family, while an employee, contracted agent or volunteer is providing services in the home. In addition, employees, contracted agents or volunteers of provider agencies are to report deaths, alleged abuse, or neglect when they become aware of such incidents regardless of where or when these incidents occur. If the death, alleged abuse or neglect occurred beyond the provider's responsibility as specified above (relating to providers) the provider is not to report the incident according to Appendix G-1-b, but instead should give notice of the incident to the individual's supports coordinator. - Individuals and families. Individuals and families are to notify the provider, when they feel it is appropriate, or their supports coordinator regarding any health and safety concerns they may have related to a service or support that they are receiving. If an individual or family member observes or suspects abuse, neglect or any inappropriate conduct, whether occurring in the home or out of the home,	

		they should contact the provider or their supports coordinator, or both and they may also contact ~~BAS~~ **ODP** directly at a toll-free number, 1-866-539-7689. The supports coordinator will either inform the involved provider of the incident or file an incident report. Once informed by the supports coordinator, the provider is subsequently responsible to take prompt action to protect the individual, complete an investigation as necessary and file an incident report. In the event of the death of an individual, the family is requested to notify the supports coordinator. ~~-~~Supports Coordinators The supports coordinator is to immediately notify the provider when an individual or family informs their supports coordinator that an event has occurred that can be defined as an incident and services or supports were: 1. Rendered at the provider's site; 2. Provided in a community environment, other than an individual's home, while the individual is the responsibility of an employee, contracted agent or volunteer; or 3. Provided in an individual's own home or the home of his family, while an employee, contracted agent or volunteer is providing services in the home. The provider is responsible for taking prompt action to protect the individual, completing an investigation as necessary and filing an incident report. When an individual or a family member informs the supports coordinator of an event that can be categorized as an incident and the provider is not responsible for reporting the incident as specified in items 1 – 3 above, the supports coordinator will take prompt action to protect the individual. The supports coordinator may need to employ the resources of law enforcement, area agency on aging, counselors or other protective service agencies to protect the individual. Once the individual's health and safety are assured the supports coordinator will report the incident to ~~BAS~~ **ODP** using the incident reporting methods described ~~below~~ **above**. The supports coordination ~~agency~~ **organization** will assign a certified investigator if necessary according to Appendix G-1-d.	

		When the individual's supports coordinator is informed of the death of the individual, the supports coordinator will determine if a report has been filed by a provider. If a provider is not required to file the report, the supports coordinator will file an incident report. If a supports coordinator is informed that a provider suspects that abuse or neglect is occurring beyond the authority of the provider to investigate as specified in items 1 – 3 above, the supports coordinator is to take all available action to protect the health and safety of the individual. The supports coordinator may need to employ the resources of law enforcement, area agency on aging, counselors or other protective service agencies to protect the individual. Once the individual's health and safety are assured the supports coordinator will report the incident to ~~BAS~~ **ODP** using the incident reporting methods described ~~below~~ **above** and the supports coordination ~~agency~~ **organization** will assign a certified investigator if necessary according to Appendix G-1-d. - ~~Bureau of Autism Services~~ **Office of Developmental Programs** In some circumstances, ~~BAS~~ **ODP** staff may be required to report incidents. ~~BAS~~ **ODP** staff are to report deaths and incidents of alleged abuse or neglect in circumstances when the process for reporting or investigating incidents, described in this waiver document, for providers or support coordination ~~entities~~ **organizations** compromises objectivity. ~~Incident Reporting Methods~~ ~~The primary method used to report incidents is EIM as described above. If EIM functionality is unavailable, the methods for reporting an incident are by fax or an e-mail to BAS of the password-protected incident management forms described above.~~ All providers must also comply with the notification requirements of 35 P.S. §§ 10225.101 -10225.5102 (Older Adults Protective Services Act) and 35 P.S. §§ 10210.101-10210.704 (Adult Protective Services Act).	

G-1-c	**Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation. When Supports Coordinators meet with the participant and his/her family or representative for the introductory meeting and subsequent ISP development meetings, Supports Coordinators must review what participants, or anyone in the participant's support team, should do if they have concerns about abuse, neglect, or exploitation and provide instructions for how to report these concerns to the Supports Coordinator or to the BAS toll-free number.	Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation. ~~When Supports Coordinators meet with the participant and his/her family or representative for the introductory meeting and subsequent ISP development meetings, Supports Coordinators must review what participants, or anyone in the participant's support team, should do if they have concerns about abuse, neglect, or exploitation and provide instructions for how to report these concerns to the Supports Coordinator or to the BAS toll-free number.~~ **Supports Coordinators deliver and discuss information concerning protections from abuse, neglect, and exploitation, including how to notify appropriate authorities. Each waiver participant receives a document that includes contact information for Supports Coordinators, local authorities, family members, and advocacy organizations. Waiver participants, families, and/or legal representatives can use this information as needed to report concerns regarding abuse, neglect, and exploitation. This information is discussed at least annually or more frequently as determined necessary by the Supports Coordinator and at the request of a participant or caregiver.**	These changes were made to align with the ID/A waivers.
G-1-d	**Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations. Entities that receive and evaluate reports: BAS evaluates all incident reports within 24 hours of their submission to determine that appropriate action to protect the individual's health, safety and rights occurred. If the appropriate actions have not taken place, BAS staff immediately communicate their concerns to the reporting entity (i.e., provider	Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations. Entities that receive and evaluate reports: **ODP receives initial notification within the EIM system when the first section of the incident report is submitted by a provider or SCO**. ~~BAS~~ **ODP** evaluates all incident reports within 24 hours of their submission to ~~determine that appropriate action to protect the individual's health, safety and rights occurred.~~ **ensure that:** ~~If the appropriate actions have not taken place, BAS~~	ODP revised the language to align with the Chapter 6100 regulations.

	or supports coordinator). BAS approval of incidents must meet criteria within the Incident Management Closure Protocol. After the provider or supports coordinator submits the final section of the Incident Report, BAS staff perform a management review within 30 days. BAS conducts the management review process so that at least 90 percent of the submitted incident reports are approved or not approved within 30 days of finalization by the provider or supports coordination entity. The management review process is to review the full report and approve or not approve the incident report. This process includes a determination that: (1) The appropriate action to protect the individual's health, safety and rights occurred. (2) The incident categorization is correct. (3) A certified investigation occurred when needed. (4) Proper safeguards are in place. (5) Corrective action in response to the incident has, or will, take place. Entities responsible for conducting investigations and how investigations are conducted: Investigations are required for the following categories of incidents defined in Appendix G-1-b: •Abuse • Death, when an individual is receiving services from a provider as specified in items 1-3 below. •Misuse of Funds •Neglect •Rights Violation •Hospitalization, when caused by one of the following: o accidental injury, o unexplained injury, o staff to individual injury, o injury resulting from individual to individual abuse, or o injury resulting from restraint • Emergency room visit, when caused by one of the following: o unexplained injury, o staff to individual injury,	~~staff immediately communicate their concerns to the reporting entity (i.e., provider or supports coordinator). BAS approval of incidents must meet criteria within the Incident Management Closure Protocol~~. **• The provider took prompt action to protect the participant's health, safety and rights. This may include but is not limited to contacting emergency services such as 911, arranging medical care, separating the perpetrator and victim, arranging counseling or referring to a victim assistance program.** **• When applicable, the provider met the mandatory reporting requirements by contacting the appropriate protective services agency for adults with a disability or older adults.** **• The provider notified the family or guardian of the incident within 24 hours (unless otherwise indicated in the individual support plan).** **• When applicable, the provider initiated an investigation by assigning the case to an ODP Certified Investigator (CI).** **ODP requires separation of the victim from the alleged perpetrator (also known as the "target" of the investigation) when an allegation of abuse, neglect, or exploitation is made, and the individual's health and safety are jeopardized. Targets may not have contact with any participants registered to receive services until the investigation is concluded. This separation may include suspending or terminating the alleged target.** ~~After the provider or supports coordinator submits the final section of the Incident Report, BAS staff perform a management review within 30 days. BAS conducts the management review process so that at least 90 percent of the submitted incident reports are approved or not approved within 30 days of finalization by the provider or supports coordination entity. The management review process is to review the full report and approve or not approve the incident report. This process includes a determination that: (1) The appropriate action to protect the individual's health, safety and rights occurred. (2) The incident categorization is correct. (3) A certified investigation occurred when~~	

	o injury resulting from individual to individual abuse, or o injury resulting from restraint •Injury requiring treatment beyond first aid, when caused by one of the following: o staff to individual injury, o injury resulting from individual to individual abuse, or o injury resulting from restraint •Individual to individual abuse, when sexual abuse is alleged Providers are responsible for investigating the above types of incidents if the alleged incident occurred when services or supports were: 1.Rendered at the provider's site; 2.Provided in a community environment, other than an individual's home, while the individual was the responsibility of an employee, contracted agent or volunteer; or 3. Provided in an individual's own home or the home of his family, while an employee, contracted agent or volunteer is providing services in the home. Supports Coordinators are responsible for investigating events that can be categorized as abuse or neglect if the provider is not responsible as specified in items 1- 3 above. Also, if a provider's certified investigator suspects that abuse or neglect is occurring beyond the authority of the provider to investigate, as specified in items 1-3 above, the supports coordinator is responsible for the investigation. BAS is responsible for investigating events that BAS must report as specified in Appendix G-1-b. For incidents that the provider must investigate, BAS conducts a separate investigation for incidents that involve either death or the use of restraint. The responsible entities identified above will assign certified investigators to conduct investigations. A certified investigator is a person who has been trained and received a certificate in investigation from ODP as communicated via Mental Retardation Bulletin 00-04-11, issued September 16, 2004, titled Announcement of Certified Investigations.	~~needed. (4) Proper safeguards are in place. (5) Corrective action in response to the incident has, or will, take place.~~ ~~Entities responsible for conducting investigations and how investigations are conducted:~~ ~~Investigations are required for the following categories of incidents defined in Appendix G-1-b:~~ ~~•Abuse~~ ~~•Death, when an individual is receiving services from a provider as specified in items 1-3 below.~~ ~~•Misuse of Funds~~ ~~•Neglect~~ ~~•Rights Violation~~ ~~•Hospitalization, when caused by one of the following:~~ ~~o accidental injury,~~ ~~o unexplained injury,~~ ~~o staff to individual injury,~~ ~~o injury resulting from individual to individual abuse, or o injury resulting from restraint~~ ~~•Emergency room visit, when caused by one of the following:~~ ~~o unexplained injury,~~ ~~o staff to individual injury,~~ ~~o injury resulting from individual to individual abuse, or o injury resulting from restraint~~ ~~•Injury requiring treatment beyond first aid, when caused by one of the following:~~ ~~o staff to individual injury,~~ ~~o injury resulting from individual to individual abuse, or o injury resulting from restraint~~ ~~•Individual to individual abuse, when sexual abuse is alleged~~ ~~Providers are responsible for investigating the above types of incidents if the alleged incident occurred when services or supports were:~~ ~~1. Rendered at the provider's site;~~	

	Certified investigators are to promptly begin an investigation, when assigned, and are to enter a summary of their investigation findings in the Incident Report. How investigations are conducted: Certified investigators conduct their investigations as per their Certified Investigator training, by conducting face-to-face interviews with the alleged victim, interviewing witnesses, reviewing witnesses' written statements, determining whether clinical input is needed (if so the BAS Clinical Team would be contacted), securing that input, and identifying and reviewing other evidence as appropriate. Certified investigators are required to complete investigation records and enter the summary of the investigator's findings into EIM. If EIM is unavailable, certified investigators must e-mail findings to BAS using a password- protected Excel form developed by BAS and investigators must e-mail the password separately to protect participant confidentiality. The summary is the compilation of the analysis and findings section of the investigation report. More information on the investigation report, is found in the Pennsylvania Certified Investigation Manual. Investigation timeframes: Investigation findings are part of final section of the incident report, mentioned in Appendix G-1-b, which must be submitted within 30 days of the incident's recognition or discovery. If the provider agency determines they will not be able to meet the 30-day reporting timeframes for completion of the final section, the provider must notify BAS prior to the expiration of the 30-day period. Process and timeframes for informing the participant and his/her family and providers of the investigation results: The provider point person must notify the participant and his or her family or representative of the occurrence of a reportable incident within 24 hours of	~~2. Provided in a community environment, other than an individual's home, while the individual was the responsibility of an employee, contracted agent or volunteer; or~~ ~~3. Provided in an individual's own home or the home of his family, while an employee, contracted agent or volunteer is providing services in the home.~~ ~~Supports Coordinators are responsible for investigating events that can be categorized as abuse or neglect if the provider is not responsible as specified in items 1- 3 above. Also, if a provider's certified investigator suspects that abuse or neglect is occurring beyond the authority of the provider to investigate, as specified in items 1-3 above, the supports coordinator is responsible for the investigation.~~ ~~BAS is responsible for investigating events that BAS must report as specified in Appendix G-1-b. For incidents that the provider must investigate, BAS conducts a separate investigation for incidents that involve either death or the use of restraint.~~ ~~The responsible entities identified above will assign certified investigators to conduct investigations. A certified investigator is a person who has been trained and received a certificate in investigation from ODP as communicated via Mental Retardation Bulletin 00-04-11, issued September 16, 2004, titled Announcement of Certified Investigations.~~ ~~Certified investigators are to promptly begin an investigation, when assigned, and are to enter a summary of their investigation findings in the Incident Report.~~ ~~How investigations are conducted:~~ ~~Certified investigators conduct their investigations as per their Certified Investigator training, by conducting face-to-face interviews with the alleged victim, interviewing witnesses, reviewing witnesses' written statements, determining whether clinical input is needed (if so the BAS Clinical Team would be contacted), securing that input, and identifying and reviewing other evidence as appropriate.~~	

	the incident, or 72 hours for medication errors, unless otherwise indicated in the ISP. The provider point person must notify the participant and his/her family or representative of the findings of any investigation unless otherwise indicated in the ISP. BAS, Supports Coordinators, and provider staff, including staff from providers not involved in the incident, must be notified of the investigation results through EIM. If EIM is unavailable, point persons must e-mail findings to BAS using a password-protected Excel form developed by BAS. Point persons must e-mail the password separately to protect participant confidentiality. Process and timelines for investigations findings that are not completed within 30 days: Final reports that are not completed within 30 days will trigger a Plan of Correction (or Corrective Action Plan). The plan of correction requires the provider to submit the final incident report as promptly as possible. Timelines are established on a case-by-case basis based on the nature of the incident and the reason the final report was not submitted on time. The state will follow-up with the provider on investigation findings within one week of the passage of the 30- day deadline and at least monthly thereafter until findings are complete and any corrective action has been implemented.	~~Certified investigators are required to complete investigation records and enter the summary of the investigator's findings into EIM. If EIM is unavailable, certified investigators must e-mail findings to BAS using a password- protected Excel form developed by BAS and investigators must e-mail the password separately to protect participant confidentiality. The summary is the compilation of the analysis and findings section of the investigation report. More information on the investigation report, is found in the Pennsylvania Certified Investigation Manual.~~ ~~Investigation timeframes:~~ ~~Investigation findings are part of final section of the incident report, mentioned in Appendix G-1-b, which must be submitted within 30 days of the incident's recognition or discovery. If the provider agency determines they will not be able to meet the 30-day reporting timeframes for completion of the final section, the provider must notify BAS prior to the expiration of the 30-day period.~~ ~~Process and timeframes for informing the participant and his/her family and providers of the investigation results:~~ ~~The provider point person must notify the participant and his or her family or representative of the occurrence of a reportable incident within 24 hours of the incident, or 72 hours for medication errors, unless otherwise indicated in the ISP. The provider point person must notify the participant and his/her family or representative of the findings of any investigation unless otherwise indicated in the ISP. BAS, Supports Coordinators, and provider staff, including staff from providers not involved in the incident, must be notified of the investigation results through EIM. If EIM is unavailable, point persons must e-mail findings to BAS using a password-protected Excel form developed by BAS. Point persons must e-mail the password separately to protect participant confidentiality.~~ ~~Process and timelines for investigations findings that are not completed within 30 days:~~	

		~~Final reports that are not completed within 30 days will trigger a Plan of Correction (or Corrective Action Plan). The plan of correction requires the provider to submit the final incident report as promptly as possible. Timelines are established on a case-by-case basis based on the nature of the incident and the reason the final report was not submitted on time. The state will follow-up with the provider on investigation findings within one week of the passage of the 30- day deadline and at least monthly thereafter until findings are complete and any corrective action has been implemented~~. **When a participant who is residing with his or her family experiences an incident that jeopardizes the victim's health and safety, the provider, SC or ODP will seek the assistance of law enforcement or Protective Service Agencies, who have the authority to remove the alleged perpetrator or the victim from the home or environment to ensure safety.** **Incidents of abuse, neglect, misuse of funds, rights violation and death are investigated by persons that have completed the Department's approved certification course. CIs follow protocols established by ODP as part of the investigatory process. CIs accommodate the witness's communication needs as appropriate and conduct interviews individually, and in a private place, if possible. If the witness requires the presence of a third party, the CI must arrange for third party representation (i.e. a staff person or family member).** **After the provider or SC submits the final section of the incident report, ODP staff perform a management review within 30 days and approve the report if:** **• The appropriate action to protect the participant's health, safety and rights occurred;** **• The incident was correctly categorized;** **• Timely completion of the certified investigation occurred;** **• The investigation summary supports the conclusion;**	

		• Safeguards to prevent reoccurrence are in place; **• Corrective actions have occurred, or are planned to occur, in response to the incident to prevent reoccurrence. When corrective actions are planned the anticipated date of completion must be indicated;** **• Changes were made in the participant's ISP necessitated by or in response to the incident;** **• The participant or participant's family received notification of the findings by the reporting entity prior to the finalization of the incident report, unless otherwise indicated in the individual plan; and** **• Incidents of abuse, neglect and exploitation were reported to the appropriate authority as required by Pennsylvania law.** **ODP disapproves reports that fail to meet the criteria described above. Disapproved reports revert to the reporting entity, who corrects any deficiencies and resubmits the report for re-evaluation. ODP will continue to work with and monitor the reporting entity to ensure appropriate adherence to the established policies. If the report is satisfactory, ODP closes the incident report.** **If additional time is needed to finalize the report, the provider can have the deadline extended. Situations that may warrant an extension of time may include but are not limited to: discharge from hospital has not occurred, investigation is not complete due to law enforcement involvement or criminal justice activities, or witnesses are not able to be interviewed timely due to extenuating circumstances.** **Supports Coordinators identify unreported incidents as they conduct monitoring of services and supports including documentation reviews. ODP identifies unreported incidents as part of the waiver participant record review sample. When an unreported incident is identified, the reviewer communicates this finding immediately to the provider who is required to**	

		ensure that an incident report is filed and appropriate action is taken to mitigate the incident and ensure action is taken to prevent reoccurrence.	
G-1-e	**Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently. BAS is responsible for the oversight of and response to critical incidents. If the provider is licensed, BAS notifies the licensing agency of the incident and coordinates response to the incident with the licensing agency. Interaction with licensing agency staff must be made within one working day of reviewing and evaluating the incident. Within 24 hours of the submission of the first section of the incident report, BAS staff review the incident to determine that appropriate action to protect the individual's health, safety, and rights occurred. In the event that the appropriate actions have not taken place the BAS staff should immediately communicate their concerns to the appropriate provider or supports coordinator. After the provider or supports coordinator submits the final section of the incident report, BAS completes a management review within 30 days. The management review process is to review the full report and approve or not approve the incident report. This process includes a determination that: • The appropriate action to protect the individual's health, safety, and rights occurred. • The incident categorization is correct. • A certified investigation occurred when needed. • Proper safeguards are in place. • Corrective action in response to the incident has, or will, take place. Prior to each of their monthly contacts with participants, supports coordinators review EIM (or if EIM functionality is unavailable – records they maintain based on e-mail notification of incidents as described in Appendix G-1-b and G-1-d) for the status of participants' incident reports and to identify the need for any ISP changes to prevent re-occurrence of any incidents.	Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently. ~~BAS~~ **ODP** is responsible for the oversight of and response to critical incidents. If the provider is licensed, ~~BAS~~ **ODP** notifies the licensing agency of the incident and coordinates response to the incident with the licensing agency. Interaction with licensing agency staff must be made within one working day of reviewing and evaluating the incident. ~~Within 24 hours of the submission of the first section of the incident report, BAS staff review the incident to determine that appropriate action to protect the individual's health, safety, and rights occurred. In the event that the appropriate actions have not taken place the BAS staff should immediately communicate their concerns to the appropriate provider or supports coordinator.~~ ~~After the provider or supports coordinator submits the final section of the incident report, BAS completes a management review within 30 days. The management review process is to review the full report and approve or not approve the incident report. This process includes a determination that:~~ ~~• The appropriate action to protect the individual's health, safety, and rights occurred.~~ ~~• The incident categorization is correct.~~ ~~• A certified investigation occurred when needed.~~ ~~• Proper safeguards are in place.~~ ~~• Corrective action in response to the incident has, or will, take place~~. **The EIM system supports incident management for ODP by allowing for the documentation and analysis of incident data. Data from EIM is used to support implementing quality improvement, risk management and incident management processes for all levels of the support and service system. Through a review of the data, ODP identifies factors that put participants at**	ODP revised the language to align with the Chapter 6100 regulations.

	BAS staff meet quarterly to review aggregated incident report data, discuss trends, identify possible causes of trends, and specify next steps for reducing participants' risk of abuse, neglect, or exploitation.	**risk and facilitates the development of interventions and improvement activities to mitigate future risk or reoccurrence. Key data elements of the incident management system include:** **• Evidence of prompt and appropriate action in response to incidents.** **• Timely reporting of incidents.** **• Investigation of incidents.** **• Corrective action in response to incidents.** **ODP staff meet quarterly to review aggregated incident report data, discuss trends, identify possible causes of trends, and specify next steps for reducing participants' risk of abuse, neglect, or exploitation.** Prior to each of their monthly contacts with participants, supports coordinators review EIM (or if EIM functionality is unavailable – records they maintain based on e-mail notification of incidents as described in Appendix G-1-b and G-1-d) for the status of participants' incident reports and to identify the need for any ISP changes to prevent re-occurrence of any incidents. ~~BAS staff meet quarterly to review aggregated incident report data, discuss trends, identify possible causes of trends, and specify next steps for reducing participants' risk of abuse, neglect, or exploitation~~	
G-2-a.i	**Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). BAS is clear on its mission to eliminate restraints as a response to challenging behaviors. BAS articulated a policy to prevent restraint use in a provider manual for all providers and in a manual specifically for supports coordinators. In addition, providers licensed by DHS to serve people with intellectual disabilities must follow practices articulated in the licensing regulations related to restraints (Title 55 PA Code, Chapters 2380, 6400, and 6500). Physical, chemical, and mechanical restraints are permitted only when consistent with the practices described below.	Safeguards Concerning the Use of Restraints**.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). ~~BAS~~ **ODP** is clear on its mission to eliminate restraints as a response to challenging behaviors. ~~BAS~~ **ODP** articulated a policy to prevent restraint use in a provider manual for all providers and in a manual specifically for supports coordinators. In addition, providers licensed by DHS to serve people with intellectual disabilities must follow practices articulated in the licensing regulations related to restraints (~~Title~~ 55 ~~PA~~ **Pa.** Code~~,~~ Chapters 2380, 6400, and 6500). ~~Physical, chemical, and mechanical restraints are permitted only when consistent with the practices described below~~.	ODP revised the language to align with the Chapter 6100 regulations.

	Use of Alternative Methods before Instituting Restraints Waiver service providers should pursue alternative strategies to the use of restraint. Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restraints. If the person receives Behavioral Support Services, the participant's behavioral support plan and crisis intervention plan identifies specific interventions tailored to the individual that anticipate and de-escalate challenging behaviors before restraints are considered necessary. Restraining a person in a prone position is prohibited. Protocols for When Restraints are Employed Restraints are always a last resort to protect an individual's health and/ or safety. Consequently, restraints are never to be used as a punishment, therapeutic technique or for staff convenience. The participant must be immediately released from the restraint as soon as it is determined that the participant is no longer a risk to him/herself or others. Manual restraint shall be used only when it has been documented that other less restrictive methods have been unsuccessful in protecting the participant from injuring him/herself or others. For each participant for whom restrictive procedures – including restraints – may be used, a restrictive procedure plan shall be written prior to the use of restrictive procedures. The restrictive procedure plan shall include methods for modifying or eliminating the behavior, such as changes in the participant's physical and social environment, changes in the participant's routine, improving communications, teaching skills and reinforcing appropriate behavior. The restrictive procedure plan shall be developed and revised by provider staff including participation of the individual's direct care staff, the behavioral specialist (if Behavioral Specialist Services are in the participant's ISP), and other professionals as appropriate. The restrictive procedure plan shall be submitted to the Supports Coordinator, who may convene the ISP team if necessary to discuss the plan. If the participant has a Behavioral Support Plan	~~Use of Alternative Methods before Instituting Restraints~~ ~~Waiver service providers should pursue alternative strategies to the use of restraint. Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restraints. If the person receives Behavioral Support Services, the participant's behavioral support plan and crisis intervention plan identifies specific interventions tailored to the individual that anticipate and de- escalate challenging behaviors before restraints are considered necessary. Restraining a person in a prone position is prohibited.~~ ~~Protocols for When Restraints are Employed~~ ~~Restraints are always a last resort to protect an individual's health and/ or safety. Consequently, restraints are never to be used as a punishment, therapeutic technique or for staff convenience. The participant must be immediately released from the restraint as soon as it is determined that the participant is no longer a risk to him/herself or others. Manual restraint shall be used only when it has been documented that other less restrictive methods have been unsuccessful in protecting the participant from injuring him/herself or others. For each participant for whom restrictive procedures – including restraints – may be used, a restrictive procedure plan shall be written prior to the use of restrictive procedures. The restrictive procedure plan shall include methods for modifying or eliminating the behavior, such as changes in the participant's physical and social environment, changes in the participant's routine, improving communications, teaching skills and reinforcing appropriate behavior.~~ ~~The restrictive procedure plan shall be developed and revised by provider staff including participation of the individual's direct care staff, the behavioral specialist (if Behavioral Specialist Services are in the participant's ISP), and other professionals as appropriate. The restrictive procedure plan shall be submitted to the Supports Coordinator, who may convene the ISP team if necessary to discuss the plan. If the participant has a Behavioral Support Plan (BSP) and a Crisis Intervention Plan (CIP) which includes restrictive procedures,~~	

	(BSP) and a Crisis Intervention Plan (CIP) which includes restrictive procedures, the BSP/CIP may serve as the restrictive procedure plan. The BSP and CIP are incorporated into the participant's ISP, and therefore, any restrictive procedure plan which is part of the BSP or CIP is also included in the ISP. The restrictive procedure plan shall include: (1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior. (2) The single behavioral outcome desired stated in observable or measurable terms. (3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing alternative appropriate behavior. (4) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used. (5) A target date for achieving the outcome. (6) The amount of time the restrictive procedure may be applied. (7) Physical problems that require special attention during the use of restrictive procedures. (8) The name of the staff person responsible for monitoring and documenting progress with the plan. The restrictive procedure plan shall be implemented as written. Supports Coordinators and providers who developed the plan shall keep copies of the restrictive procedure plan in the individual's record. Providers who use restraints as part of their operating procedures must have a restrictive procedure review committee. This committee must review and revise (if necessary) the restrictive procedure plan at least every 6 months. Methods for Detecting Unauthorized use of Restraints or Seclusion As articulated in Appendix G-1, BAS defines the unauthorized use of physical, chemical, or mechanical restraints as a form of abuse and requires providers to report incidents of abuse within 24 hours of occurrence or discovery. The Provider Manual and Supports Coordinator Manual also define the types of	~~the BSP/CIP may serve as the restrictive procedure plan. The BSP and CIP are incorporated into the participant's ISP, and therefore, any restrictive procedure plan which is part of the BSP or CIP is also included in the ISP.~~ ~~The restrictive procedure plan shall include:~~ ~~(1)The specific behavior to be addressed and the suspected antecedent or reason for the behavior.~~ ~~(2)The single behavioral outcome desired stated in observable or measurable terms.~~ ~~(3)Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing alternative appropriate behavior.~~ ~~(4) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.~~ ~~(5) A target date for achieving the outcome.~~ ~~(6) The amount of time the restrictive procedure may be applied.~~ ~~(7) Physical problems that require special attention during the use of restrictive procedures.~~ ~~(8) The name of the staff person responsible for monitoring and documenting progress with the plan.~~ ~~The restrictive procedure plan shall be implemented as written. Supports Coordinators and providers who developed the plan shall keep copies of the restrictive procedure plan in the individual's record. Providers who use restraints as part of their operating procedures must have a restrictive procedure review committee. This committee must review and revise (if necessary) the restrictive procedure plan at least every 6 months.~~ **ODP only permits physical restraints, defined as a manual method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely. Physical restraints may only be used in the case of an emergency to prevent an individual from immediate physical harm to himself or others. A physical restraint may not be used for more than 30 cumulative minutes within a 2-hour period.**	

	unauthorized restraints so providers can detect and report these abuses. All incidents are reportable through EIM or – if EIM functionality is unavailable – via e-mail as described in Appendix G-1-b. After any use of a restraint, the Supports Coordinator must meet with the participant and his or her planning team for a post-restraint debriefing to determine how future situations can be prevented. The Supports Coordinator records information from the debriefing sessions in HCSIS as part of his or her service notes. These discussions can be separate and distinct with the intended purpose of determining what could have been done differently to avoid the restraint. Any changes to the individual's plan shall be documented in the ISP. During the monitoring visits described in Appendix D, the Supports Coordinator assesses the participant's health and welfare. If the participant or another individual informs the Supports Coordinator of an unreported use of restraint, the Supports Coordinator shall 1) take whatever immediate steps are necessary to ensure the participant's health and welfare, and 2) report the incident according to the policy in Appendix G-1. Education and Training Requirements for Personnel who Administer Restraints and Seclusion BAS has several resources available to providers to educate and train staff regarding the safe use of restraint and the reduction and elimination of restraints. A list of training resources is found in ODP Bulletin 00-06- 09 Elimination of Restraints through Positive Practice. BAS requires providers who administer restraints to submit their planned staff training curricula for review and approval. BAS validates implementation of staff training as part of provider monitoring Training Training should be ongoing for all staff and should focus on overall supports for improving an individual's quality of life while maintaining his or her health and welfare. Acknowledging that there are providers that continue to serve	**Physical restraints may be used only as a last resort safety measure when the participant is in immediate danger of harming him or herself and/or others and less restrictive techniques and resources have been tried but failed. A physical restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for staffing or individual support.** **The following restraints are prohibited:** **•Seclusion, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving. Seclusion includes physically holding a door shut or using a foot pressure lock.** **• Prone position physical restraints and any physical restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints or allows for a free fall to the floor.** **• Aversive conditioning, defined as the application of startling, painful or noxious stimuli.** **• Pressure point techniques, defined as the application of pain for the purpose of achieving compliance. A clinically-accepted bite release technique that is applied only as long as necessary to release the bite is not considered a pressure point technique.** **• A chemical restraint, defined as a drug used for the specific and exclusive purpose of controlling acute, episodic behavior. A Pro Re Nata (PRN) order for controlling acute, episodic behavior is a chemical restraint.** **• A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body, including a geriatric chair, bedrail that restricts the movement or function of the individual, helmet with fasteners, waist strap, head strap, restraint vest, camisole, restraining sheet, restraint board, handcuffs, anklets, wristlets, muffs and mitts with fasteners, chest restraint, and other similar devices. A mechanical restraint does not include the use of a seat belt during movement or transportation.** **Physical restraints must be included in the service plan and must be approved by a human rights team prior to implementation. The service plan**	

	and support individuals in a restraint-free environment and provide extensive training for their staff, the guidelines issued by ODP are to be viewed as minimal expectations to help support the person and create a structure that prevents restraint. All providers should have procedures in place that address how people are supported in emergency situations where an individual's health and welfare may be at risk. All staff should have initial training within 30 calendar days after their first day of employment and prior to working directly with an individual, or have documented training that has occurred within the past 12 months. Ongoing training is expected to occur within every calendar year. Training in the application of restraints is needed only for those providers who utilize restraint as part of their operating procedures. The following curriculum of training is required for those providers who utilize restraints. •Environmental design and social, physiological, and cultural motivators for behavior, including information on individuals who have experienced trauma such as abuse. This includes understanding the impact of environmental factors and triggers. •Positive behavioral support methods that include techniques to de-escalate behavior; listening and communication skills; teaching functionally equivalent replacement behaviors; awareness of environmental factors that can cause disruptive behaviors; violence prevention and conflict resolution; and how to complete a FBA. •Information on "best practice" methods for interacting with individuals who have a dual diagnosis of ASD and a mental illness. This includes the effects of medications, how medication changes can impact behavior, and teaching alternative strategies and other coping mechanisms. •Person-centered alternatives to the use of restraint, including an understanding of which positive behavior supports are most effective with particular individuals and teaching strategies that emphasize prevention of future challenging incidents. This includes the integration of effective behavioral supports. •Basic training in body mechanics that illustrates how to avoid hyperextensions and other positions that may endanger individual safety.	**must be reviewed, and revised, if necessary, according to the time frame established by the human rights team, not to exceed 6 months.** **The service plan with restrictive interventions, including physical restraints, must include:** **(1) The specific behavior to be addressed.** **(2) An assessment of the behavior including the suspected reason for the behavior.** **(3) The outcome desired.** **(4) Methods for facilitating positive behaviors such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, recognizing and treating physical and behavior health conditions, voluntary physical exercise, redirection, praise, modeling, conflict resolution, de-escalation and teaching skills.** **(5) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.** **(6) A target date to achieve the outcome.** **(7) The amount of time the restrictive procedure may be applied.** **(8) The name of the staff person responsible for monitoring and documenting progress with the individual plan.** **Through review of the incident report and individual support plans, ODP monitors both the use of approved physical restraints and the procedures used when or if such methods were employed. This process is also used to ensure that no providers have utilized the prohibited practices of seclusion or prone position restraint.** **ODP detects unauthorized or misapplied physical restraints through the various oversight and monitoring processes. Physical restraints that do not follow ODP standards are reported as abuse.** **According to ODP policy, a participant's physical condition must be evaluated throughout the physical restraint in order to minimize the potential of individual harm or injury. A participant is immediately released from a physical restraint when he or she no longer presents a danger to self or**	

	•Awareness of an individual's health history in order to assess increased risk that may occur during the application of a restraint. •The use of physical restraints, including the proper application of restraints appropriate to the age, weight, and diagnosis of the individual. Also, the possible negative psychological effects of restraint, and monitoring an individual's physical condition for signs of distress or trauma. •Definitions of restraint; policies on the use of restraints; the risks associated with the use of restraints; and staff experience the use of physical restraint applies to themselves. This includes debriefing techniques with the individuals they support as well as staff members.	**others. Support staff monitors the participant for signs of distress throughout the restraint process and for a period of time (up to 2 hours) following the application of a physical restraint.** **All anticipated physical restraint usage must be reviewed with the individual's Primary Care Physician (PCP) to ensure that there are no potential negative health and safety impacts. For example, a PCP may not agree to allow a physical restraint to be used for an individual with osteoporosis due to the risk of a broken bone.** Methods for Detecting Unauthorized use of Restraints or Seclusion As articulated in Appendix G-1, ~~BAS~~ **ODP** defines the unauthorized use of physical~~, chemical, or mechanical~~ restraints as a form of abuse and requires providers to report incidents of abuse within 24 hours of occurrence or discovery. The Provider Manual and Supports Coordinator Manual also define the types of unauthorized restraints so providers can detect and report these abuses. All incidents are reportable through EIM or – if EIM functionality is unavailable – via e-mail as described in Appendix G-1-b. After any use of a restraint, the Supports Coordinator must meet with the participant and his or her planning team for a post-restraint debriefing to determine how future situations can be prevented. The Supports Coordinator records information from the debriefing sessions in HCSIS as part of his or her service notes. These discussions can be separate and distinct with the intended purpose of determining what could have been done differently to avoid the restraint. Any changes to the individual's plan shall be documented in the ISP. During the monitoring visits described in Appendix D, the Supports Coordinator assesses the participant's health and welfare. If the participant or another individual informs the Supports Coordinator of an unreported use of restraint, the Supports Coordinator shall 1) take whatever immediate steps are necessary to ensure the participant's health and welfare, and 2) report the incident according to the policy in Appendix G-1.	

		~~Education and Training Requirements for Personnel who Administer Restraints and Seclusion~~ ~~BAS has several resources available to providers to educate and train staff regarding the safe use of restraint and the reduction and elimination of restraints. A list of training resources is found in ODP Bulletin 00-06-09 Elimination of Restraints through Positive Practice.~~ ~~BAS requires providers who administer restraints to submit their planned staff training curricula for review and approval. BAS validates implementation of staff training as part of provider monitoring~~ Training **Staff that administer physical restraints must have specific training regarding the appropriate use and safe implementation, as well as de-escalation techniques/alternatives. This training must be completed within the past 12 months and focus on the proper procedures and specific techniques to follow, ethics of using physical restraints and alternative positive approaches. ODP validates implementation of staff training as part of provider monitoring.** **ODP utilizes a person-centered planning model for all activities associated with provider training for authorized physical restraints. Training and education for administering a physical restraint is based on the unique needs of the individual as outlined in the service plan. ODP requires that staff associated with waiver services that may need to employ a physical restraint be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.** Training should be ongoing for all staff and should focus on overall supports for improving an individual's quality of life while maintaining his or her health and welfare. Acknowledging that there are providers that continue to serve and support individuals in a restraint-free environment and provide extensive training for their staff, the guidelines issued by ODP are to be viewed as minimal expectations to help support the person and create a structure that	

		prevents restraint. All providers should have procedures in place that address how people are supported in emergency situations where an individual's health and welfare may be at risk. ~~All staff should have initial training within 30 calendar days after their first day of employment and prior to working directly with an individual, or have documented training that has occurred within the past 12 months. Ongoing training is expected to occur within every calendar year. Training in the application of restraints is needed only for those providers who utilize restraint as part of their operating procedures.~~ **Training curricula is directly related to the service plan that includes the use of physical restraints. Staff training must occur prior to rendering services to a participant and annually. Examples of the types of education and trainings include multiple nationally recognized intervention programs that focus on the use of least restrictive interventions, such as Safe Crisis Management Certification Training Program and Crisis Prevention Institute's techniques of Nonviolent Crisis Management.** ~~The following curriculum of training is required for those providers who utilize restraints.~~ ~~•Environmental design and social, physiological, and cultural motivators for behavior, including information on individuals who have experienced trauma such as abuse. This includes understanding the impact of environmental factors and triggers.~~ ~~•Positive behavioral support methods that include techniques to de-escalate behavior; listening and communication skills; teaching functionally equivalent replacement behaviors; awareness of environmental factors that can cause disruptive behaviors; violence prevention and conflict resolution; and how to complete a FBA.~~ ~~•Information on "best practice" methods for interacting with individuals who have a dual diagnosis of ASD and a mental illness. This includes the effects of medications, how medication changes can impact behavior, and teaching alternative strategies and other coping mechanisms.~~ ~~•Person-centered alternatives to the use of restraint, including an understanding of which positive behavior supports are most effective with~~	

		~~particular individuals and teaching strategies that emphasize prevention of future challenging incidents. This includes the integration of effective behavioral supports.~~ ~~•Basic training in body mechanics that illustrates how to avoid hyperextensions and other positions that may endanger individual safety.~~ ~~•Awareness of an individual's health history in order to assess increased risk that may occur during the application of a restraint.~~ ~~•The use of physical restraints, including the proper application of restraints appropriate to the age, weight, and diagnosis of the individual. Also, the possible negative psychological effects of restraint, and monitoring an individual's physical condition for signs of distress or trauma.~~ ~~•Definitions of restraint; policies on the use of restraints; the risks associated with the use of restraints; and staff experience the use of physical restraint applies to themselves. This includes debriefing techniques with the individuals they support as well as staff members.~~	
G-2-a.ii	**State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency: BAS is responsible for oversight of the use of restraints. BAS analyzes data on restraint as part of the regular analysis of incident data described in Appendix G-1. BAS also will review Supports Coordinator notes and provider records for a sample of participants and interview those participants. The review and interviews include questions to identify appropriate and inappropriate use of restraint. BAS will require corrective action if necessary. BAS will review individual occurrences of the use of restraints within 24 hours of occurrence. BAS staff meet quarterly to review aggregated data, discuss trends, identify possible causes of trends and specify next steps for eliminating inappropriate use of restraints.	State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency: ~~BAS~~ **ODP** is responsible for oversight of the use of restraints. ~~BAS~~ **ODP** analyzes data on restraint **and unauthorized restraints** as part of the regular analysis of incident data described in Appendix G-1. ~~BAS~~ **ODP** also will review Supports Coordinator notes and provider records for a sample of participants and interview those participants. The review and interviews include questions to identify appropriate and inappropriate use of restraint. ~~BAS~~ **ODP** will require corrective action if necessary. ~~BAS~~ **ODP** will review individual occurrences of the use of restraints within 24 hours of occurrence. ~~BAS~~ **ODP** staff meet quarterly to review aggregated data, discuss trends, identify possible causes of trends and specify next steps for eliminating inappropriate use of restraints.	ODP revised the language to align with the Chapter 6100 regulations.
G-2-b.i	**Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws,	Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations,	ODP revised the language to align with the Chapter 6100 regulations.

	regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency. DHS encourages use of positive behavioral supports and discourages restrictive interventions. BAS articulated this policy in a provider manual for all providers and a manual specifically for supports coordinators. In addition, providers licensed by DHS to serve people with intellectual disabilities must follow practices articulated in the licensing regulations related to restraints and seclusion (Title 55 PA Code, Chapters 2380, 6400, and 6500). Use of Alternative Methods before Instituting Restrictive Interventions Waiver service providers are to pursue alternative strategies to the use of restrictive interventions. Every attempt should be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive interventions. If the person receives Specialized Skill Development Services, the participant's Behavioral Support Plan (BSP) and Crisis Intervention Plan (CIP) identifies specific interventions tailored to the individual that anticipate and de-escalate challenging behaviors before restrictive interventions are considered necessary. A restrictive intervention is a practice that limits an individual's movement, activity of function; interferes with an individual's ability to acquire positive reinforcement; results in the loss of objects or activities that an individual values; or requires an individual to engage in a behavior that the individual would not engage in given freedom of choice. A restrictive intervention may not be used as retribution, for the convenience of the family (staff persons), as a substitute for the program or in a way that interferes with the individual's developmental program. For each incident requiring restrictive interventions: • Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive interventions. • A restrictive intervention may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.	and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency. ~~DHS~~ **ODP** encourages use of positive behavioral supports and discourages restrictive interventions. ~~BAS~~ **ODP** articulated this policy in a provider manual for all providers and a manual specifically for supports coordinators. In addition, providers licensed by DHS to serve people with intellectual disabilities must follow practices articulated in the licensing regulations related to restraints and seclusion (~~Title~~ 55 ~~PA~~ **Pa.** Code~~,~~ Chapters 2380, 6400, and 6500). ~~Use of Alternative Methods before Instituting Restrictive Interventions~~ ~~Waiver service providers are to pursue alternative strategies to the use of restrictive interventions. Every attempt should be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive interventions. If the person receives Specialized Skill Development Services, the participant's Behavioral Support Plan (BSP) and Crisis Intervention Plan (CIP) identifies specific interventions tailored to the individual that anticipate and de-escalate challenging behaviors before restrictive interventions are considered necessary.~~ ~~A restrictive intervention is a practice that limits an individual's movement, activity of function; interferes with an individual's ability to acquire positive reinforcement; results in the loss of objects or activities that an individual values; or requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.~~ ~~A restrictive intervention may not be used as retribution, for the convenience of the family (staff persons), as a substitute for the program or in a way that interferes with the individual's developmental program. For each incident requiring restrictive interventions:~~ ~~• Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive interventions.~~ ~~• A restrictive intervention may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.~~	

	The use of aversive conditioning, defined as the application, contingent upon the exhibition of challenging behavior, of startling, painful or noxious stimuli, is prohibited. Protocols for When Restrictive Interventions are Employed For each participant for whom restrictive interventions may be used, a restrictive intervention plan shall be written prior to the use of restrictive intervention. The restrictive intervention plan shall include methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing appropriate behavior. The restrictive intervention plan shall be developed and revised by provider staff including participation of the individual's direct care staff, the behavioral specialist (if Behavioral Specialist Services are in the participant's ISP), and other professionals as appropriate. The restrictive intervention plan shall be submitted to the Supports Coordinator, who may convene the ISP team if necessary to discuss the plan. If the participant has a Behavioral Support Plan (BSP) and a Crisis Intervention Plan (CIP) which includes restrictive interventions, the BSP/CIP may serve as the restrictive intervention plan. The restrictive intervention plan shall include: (1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior. (2) The single behavioral outcome desired stated in observable or measurable terms. (3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing alternative appropriate behavior. (4) Types of restrictive interventions that may be used and the circumstances under which the interventions may be used. (5) A target date for achieving the outcome.	~~The use of aversive conditioning, defined as the application, contingent upon the exhibition of challenging behavior, of startling, painful or noxious stimuli, is prohibited.~~ ~~Protocols for When Restrictive Interventions are Employed~~ ~~For each participant for whom restrictive interventions may be used, a restrictive intervention plan shall be written prior to the use of restrictive intervention. The restrictive intervention plan shall include methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing appropriate behavior. The restrictive intervention plan shall be developed and revised by provider staff including participation of the individual's direct care staff, the behavioral specialist (if Behavioral Specialist Services are in the participant's ISP), and other professionals as appropriate. The restrictive intervention plan shall be submitted to the Supports Coordinator, who may convene the ISP team if necessary to discuss the plan. If the participant has a Behavioral Support Plan (BSP) and a Crisis Intervention Plan (CIP) which includes restrictive interventions, the BSP/CIP may serve as the restrictive intervention plan.~~ ~~The restrictive intervention plan shall include:~~ ~~(1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior.~~ ~~(2) The single behavioral outcome desired stated in observable or measurable terms.~~ ~~(3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing alternative appropriate behavior.~~ ~~(4) Types of restrictive interventions that may be used and the circumstances under which the interventions may be used.~~ ~~(5) A target date for achieving the outcome.~~ ~~(6) The amount of time the restrictive intervention may be applied.~~	

	(6) The amount of time the restrictive intervention may be applied. (7) Physical problems that require special attention during the use of restrictive interventions. (8) The name of the staff person responsible for monitoring and documenting progress with the plan. The restrictive intervention plan shall be implemented as written. Supports Coordinators and providers who developed the plan shall keep copies of the restrictive intervention plan in the individual's record. Providers who use restrictive interventions as part of their operating procedures must have a restrictive intervention review committee. This committee must review and revise (if necessary) the restrictive intervention plan at least every 6 months. A record of each use of a restrictive intervention documenting the specific behavior addressed, methods of intervention used to address the behavior, the date and time the restrictive intervention was used, the specific procedures followed, the staff person who used the restrictive intervention, the duration of the restrictive intervention, the staff person who observed the individual if seclusion was used and the individual's condition during and following the removal of the restrictive intervention shall be kept in the individual's record. Methods for Detecting Unauthorized use of Restrictive Interventions During the monitoring visits described in Appendix D, the Supports Coordinator interviews the participant and others involved in the participant's services to identify any concerns regarding the participant's health and welfare. The Supports Coordinator reviews the provider's record for documentation of restrictive interventions. If restrictive interventions are documented or if the participant or another individual reports undocumented usage of restrictive interventions, the Supports Coordinator shall 1) take whatever immediate steps are necessary to ensure the participant's health and welfare, and 2) meet with the participant and his or her planning team to determine how to prevent the usage of restrictive interventions. The Supports Coordinator records information from the debriefing sessions in HCSIS as part of his or her service notes. Any changes to the individual's plan shall be documented in the ISP.	~~(7) Physical problems that require special attention during the use of restrictive interventions.~~ ~~(8) The name of the staff person responsible for monitoring and documenting progress with the plan.~~ **Use of Alternative Methods Before Instituting Restrictive Interventions** **Waiver service providers are to pursue alternative strategies to the use of restrictive interventions. If the person receives Specialized Skill Development Services, the participant's Behavioral Support Plan (BSP) and Crisis Intervention Plan (CIP) identifies specific interventions tailored to the individual that anticipate and de-escalate challenging behaviors before restrictive interventions are considered necessary.** **A restrictive intervention is a practice that limits an individual's movement, activity or function; interferes with an individual's ability to acquire positive reinforcement; results in the loss of objects or activities that an individual values; or requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.** **A restrictive intervention may not be used as retribution, for the convenience of the staff persons or family, as a substitute for the program or in a way that interferes with the individual's developmental program. For each incident requiring restrictive interventions:** **• Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive interventions.** **• A restrictive intervention may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.** **The use of aversive conditioning, defined as the application, contingent upon the exhibition of challenging behavior, of startling, painful or noxious stimuli, is prohibited.** **Providers who use restrictive interventions as part of their operating procedures must have a restrictive intervention review committee.**	

	Education and Training Requirements for Personnel who Administer Restrictive Interventions ODP has several resources available to providers to educate and train staff regarding the reduction and elimination of restrictive interventions. A list of training resources is found in ODP Bulletin 00-06-09 Elimination of Restraints through Positive Practice. BAS requires providers who administer restrictive interventions to submit their planned staff training curricula for review and approval. BAS validates implementation of staff training as part of provider monitoring. Training All staff should have initial training within 30 calendar days after their first day of employment and prior to working directly with an individual, or have documented training that has occurred within the past 12 months. Ongoing training is expected to occur within every calendar year. Training in the application of restrictive interventions is necessary only for those providers who utilize these interventions as part of their operating procedures. The following curriculum of training is required for those providers who utilize restrictive interventions: •Environmental design and social, physiological, and cultural motivators for behavior, including information on individuals who have experienced trauma such as abuse. This includes understanding the impact of environmental factors and triggers. •Positive behavioral support methods that include techniques to de-escalate behavior; listening and communication skills; teaching functionally equivalent replacement behaviors; awareness of environmental factors that can cause disruptive behaviors; violence prevention and conflict resolution; and how to complete a Functional Behavioral Assessment. •Information on "best practice" methods for interacting with individuals who have a dual diagnosis of ASD and a mental illness. This includes the effects of medications, how medication changes can impact behavior, and teaching alternative strategies and other coping mechanisms.	**Restrictive procedure plans must be developed and approved by a human rights team prior to implementation. The restrictive procedure plan must be reviewed, and revised, if necessary, according to the time frame established by the human rights team, not to exceed 6 months.** **The service plan with restrictive interventions, including physical restraints, must include:** **(1) The specific behavior to be addressed.** **(2) An assessment of the behavior including the suspected reason for the behavior.** **(3) The outcome desired.** **(4) Methods for facilitating positive behaviors such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, recognizing and treating physical and behavior health conditions, voluntary physical exercise, redirection, praise, modeling, conflict resolution, de-escalation and teaching skills.** **(5) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.** **(6) A target date to achieve the outcome.** **(7) The amount of time the restrictive procedure may be applied.** **(8) The name of the staff person responsible for monitoring and documenting progress with the individual plan.** **Permitted restrictive interventions include:** **• Token economies or other reward and/or level systems as part of programming.** **• Environmental restrictions.** **• Limiting access to objects or items, such as limiting access to food for participants diagnosed with Prader Willi.**	

	•Person-centered alternatives to restrictive interventions, including an understanding of which positive practices are most effective with particular individuals and teaching strategies that emphasize prevention of future negative incidents. This includes the integration of effective behavioral supports. •Awareness of an individual's health history in order to assess increased risk that may occur during the application of a restrictive intervention. •Definitions of restrictive interventions; policies on the use of restrictive interventions; and the risks associated with these interventions. This includes debriefing techniques with the individuals they support as well	**• Any requirement that a person is legally mandated to follow as part of probation or a court restriction that supersedes regulation or other ODP policy.** **Prohibited restrictive interventions include:** **• The use of aversive conditioning; defined as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful or noxious stimuli.** **• Access to or the use of a participant's personal funds or property may not be used as reward or punishment. A participant's personal funds or property may not be used as payment for damages unless the participant consents to make restitution for the damages.** The restrictive intervention plan shall be implemented as written. Supports Coordinators and providers who developed the plan shall keep copies of the restrictive intervention plan in the individual's record. ~~Providers who use restrictive interventions as part of their operating procedures must have a restrictive intervention review committee~~. ~~This committee must review and revise (if necessary) the restrictive intervention plan at least every 6 months.~~ A record of each use of a restrictive intervention documenting the specific behavior addressed, methods of intervention used to address the behavior, the date and time the restrictive intervention was used, the specific procedures followed, the staff person who used the restrictive intervention, the duration of the restrictive intervention, the staff person who observed the individual if seclusion was used and the individual's condition during and following the removal of the restrictive intervention shall be kept in the individual's record. **ODP requires documentation of restrictive intervention usage as part of the progress notes completed by provider staff. ODP utilizes a person-centered planning model for all activities associated with provider training for authorized restrictive interventions. Training and education surrounding restrictive interventions are based on the unique needs of the individual as outlined in the restrictive intervention plan. The curriculum is based on the specific techniques outlined in the restrictive intervention plan. ODP**	

		requires that staff associated with waiver services that may need to employ a restrictive intervention be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs. **Training curricula is directly related to the service plan that includes the use of restrictive interventions. Staff training must occur prior to rendering services to a participant and annually.** Methods for Detecting Unauthorized use of Restrictive Interventions During the monitoring visits described in Appendix D, the Supports Coordinator interviews the participant and others involved in the participant's services to identify any concerns regarding the participant's health and welfare. The Supports Coordinator reviews the provider's record for documentation of restrictive interventions. If restrictive interventions are documented or if the participant or another individual reports undocumented usage of restrictive interventions, the Supports Coordinator shall 1) take whatever immediate steps are necessary to ensure the participant's health and welfare, and 2) meet with the participant and his or her planning team to determine how to prevent the usage of restrictive interventions. The Supports Coordinator records information from the debriefing sessions in HCSIS as part of his or her service notes. Any changes to the individual's plan shall be documented in the ISP. ~~Education and Training Requirements for Personnel who Administer Restrictive Interventions~~ ~~ODP has several resources available to providers to educate and train staff regarding the reduction and elimination of restrictive interventions. A list of training resources is found in ODP Bulletin 00-06-09 Elimination of Restraints through Positive Practice.~~ ~~BAS requires providers who administer restrictive interventions to submit their planned staff training curricula for review and approval. BAS validates implementation of staff training as part of provider monitoring.~~	

		~~Training~~ ~~All staff should have initial training within 30 calendar days after their first day of employment and prior to working directly with an individual, or have documented training that has occurred within the past 12 months. Ongoing training is expected to occur within every calendar year. Training in the application of restrictive interventions is necessary only for those providers who utilize these interventions as part of their operating procedures. The following curriculum of training is required for those providers who utilize restrictive interventions:~~ ~~•Environmental design and social, physiological, and cultural motivators for behavior, including information on individuals who have experienced trauma such as abuse. This includes understanding the impact of environmental factors and triggers.~~ ~~•Positive behavioral support methods that include techniques to de-escalate behavior; listening and communication skills; teaching functionally equivalent replacement behaviors; awareness of environmental factors that can cause disruptive behaviors; violence prevention and conflict resolution; and how to complete a Functional Behavioral Assessment.~~ ~~•Information on "best practice" methods for interacting with individuals who have a dual diagnosis of ASD and a mental illness. This includes the effects of medications, how medication changes can impact behavior, and teaching alternative strategies and other coping mechanisms.~~ ~~•Person-centered alternatives to restrictive interventions, including an understanding of which positive practices are most effective with particular individuals and teaching strategies that emphasize prevention of future negative incidents. This includes the integration of effective behavioral supports.~~ ~~•Awareness of an individual's health history in order to assess increased risk that may occur during the application of a restrictive intervention.~~ ~~•Definitions of restrictive interventions; policies on the use of restrictive interventions; and the risks associated with these interventions. This includes debriefing techniques with the individuals they support as well~~	
G-2-b.ii	**State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:	State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:	ODP revised the language to align

	BAS is responsible for oversight of the use of restrictive interventions. BAS analyzes data on restrictive interventions as part of the regular analysis of incident data described in Appendix G-1. BAS also will review Supports Coordinator notes and provider records for a sample of participants and interview those participants. The review and interviews include questions to identify appropriate and inappropriate use of restrictive interventions. BAS will require corrective action if necessary. BAS will review individual occurrences of the use of restrictive interventions within 24 hours of occurrence. BAS staff meet quarterly to review aggregated data, discuss trends, identify possible causes of trends and specify next steps for eliminating inappropriate use of restrictive interventions.	~~BAS is responsible for oversight of the use of restrictive interventions. BAS analyzes data on restrictive interventions as part of the regular analysis of incident data described in Appendix G-1. BAS also will review Supports Coordinator notes and provider records for a sample of participants and interview those participants. The review and interviews include questions to identify appropriate and inappropriate use of restrictive interventions. BAS will require corrective action if necessary. BAS will review individual occurrences of the use of restrictive interventions within 24 hours of occurrence. BAS staff meet quarterly to review aggregated data, discuss trends, identify possible causes of trends and specify next steps for eliminating inappropriate use of restrictive interventions.~~ **ODP oversees the use of restrictive interventions through oversight monitoring activities. Restrictive intervention procedure plans are approved by a human rights team prior to the use of any restrictive intervention. The only exception to using a restrictive intervention without an approved plan is when the intervention is used for the first time during an emergency situation in order to protect the health and safety of a participant. Restrictive interventions that do not follow ODP guidelines are reported as an incident of a rights violation and investigated. As a result of the investigation and incident management process, strategies are developed to prevent reoccurrence. In addition, through the person-centered planning process, the team regularly meets to review and discuss progress, lack of progress, and any overuse of restrictive interventions.** **As part of the Department's annual licensing inspection process for licensed settings, licensing staff reviews service plans to identify participants who have restrictive interventions in place and to verify that restrictive intervention procedure plan regulations have been met. Providers that frequently use restrictive interventions are provided technical assistance, training and other resources needed to decrease restrictive intervention usage.**	with the Chapter 6100 regulations.
G-2-c	**Use of Seclusion.** **X The State does not permit or prohibits the use of seclusion**	Use of Seclusion. X The State does not permit or prohibits the use of seclusion	ODP revised the language to align with the Chapter 6100 regulations.

	Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency: BAS is responsible for detecting the unauthorized use of seclusion. BAS analyzes data on seclusion as part of the regular analysis of incident data described in Appendix G-1. BAS also will review Supports Coordinator notes and provider records for a sample of participants and interview those participants. The review and interviews include questions to identify unauthorized of seclusion. BAS will require corrective action if necessary. BAS will review individual occurrences of the use of seclusion within 24 hours of occurrence. The processes for remediation in cases of seclusion are the same as those for restraint as explained in Appendix G (2)(c): BAS is responsible for detecting the unauthorized use of seclusion. BAS analyzes data on seclusion as part of the regular analysis of incident data described in Appendix G-1. BAS also will review Supports Coordinator notes and provider records for a sample of participants and interview those participants. The review and interviews include questions to identify unauthorized of seclusion. BAS will require corrective action if necessary. BAS will review individual occurrences of the use of seclusion within 24 hours of occurrence. When BAS discovers a provider is using seclusion, providers must stop the practice within one business day. BAS has behavioral management experts who will assist the provider in developing positive interventions to use in place of seclusion.	Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency: **ODP prohibits seclusion as a type of restrictive intervention.** ~~BAS~~ **ODP** is responsible for detecting the unauthorized use of seclusion. ~~BAS~~ **ODP** analyzes data on seclusion as part of the regular analysis of incident data described in Appendix G-1. ~~BAS~~ **ODP** also will review Supports Coordinator notes and provider records for a sample of participants and interview those participants. The review and interviews include questions to identify unauthorized **use** of seclusion. ~~BAS~~ **ODP** will require corrective action if necessary. ~~BAS~~ **ODP** will review individual occurrences of the use of seclusion within 24 hours of occurrence. The processes for remediation in cases of seclusion are the same as those for restraint as explained in Appendix G (2)(c): ~~BAS is responsible for detecting the unauthorized use of seclusion. BAS analyzes data on seclusion as part of the regular analysis of incident data described in Appendix G-1. BAS also will review Supports Coordinator notes and provider records for a sample of participants and interview those participants. The review and interviews include questions to identify unauthorized of seclusion. BAS will require corrective action if necessary. BAS will review individual occurrences of the use of seclusion within 24 hours of occurrence.~~ ~~When BAS discovers a provider is using seclusion, providers must stop the practice within one business day. BAS has behavioral management experts who will assist the provider in developing positive interventions to use in place of seclusion.~~ **When alleged seclusion has been identified, the usage is reported as an incident of a rights violation and investigated. As a result of the investigation and incident management process, strategies are developed to prevent reoccurrence.**	
Appendix G-Quality Improvement: Health and Welfare			
G-a.i.a	**Performance Measure PS1: Number and percent of confirmed incidents of abuse, neglect, exploitation and unexplained death for which corrective**	Performance Measure ~~PS1~~ **HW1**: Number and percent of confirmed incidents of abuse, neglect, exploitation and unexplained death for which corrective	These changes were made to align

	action was taken. Numerator = Number of confirmed incidents of abuse, neglect, exploitation and unexplained death for which corrective action was taken. Denominator = Number of confirmed incidents of abuse, neglect, exploitation and unexplained death. **Performance Measure PS2: Number and percent of participants who received information about how to identify and report abuse, neglect and exploitation. Numerator = Number of participants who received information about how to identify and report abuse, neglect and exploitation. Denominator = Number of participants reviewed.** **Data Source** (Select one): **Other** If 'Other' is selected, specify: **Provider monitoring**	action was taken. Numerator = Number of confirmed incidents of abuse, neglect, exploitation and unexplained death for which corrective action was taken. Denominator = Number of confirmed incidents of abuse, neglect, exploitation and unexplained death. Performance Measure ~~PS2~~ **HW2**: Number and percent of participants who received information about how to identify and report abuse, neglect and exploitation. Numerator = Number of participants who received information about how to identify and report abuse, neglect and exploitation. Denominator = Number of participants reviewed. Data Source (Select one): Other If 'Other' is selected, specify: ~~Provider monitoring~~ **Participant Record Review**	with the ID/A waivers.
G-a.i.b	**Performance Measure PS3: Number and percent of investigated incidents where the provider's corrective action plan (CAP) includes strategies to mitigate/prevent future incident. Numerator = Number of incidents where the provider's CAP includes strategies to mitigate/prevent future incident. Denominator = All investigated incidents where the provider is required to develop a CAP.** **Data Source (Select one):** **Other** If 'Other' is selected, specify: **Enterprise Incident Management (EIM)and IM spreadsheet** **Performance Measure PS4: Number and percent of participants with a confirmed incident which are reported and reviewed at quarterly risk management meetings to determine any patterns related to participants or providers. Numerator = Participants with a confirmed incident which are reported to quarterly risk management meetings. Denominator = All confirmed incidents.** **Data Source** (Select one):	Performance Measure ~~PS3: Number and percent of investigated incidents where the provider's corrective action plan (CAP) includes strategies to mitigate/prevent future incidents. Numerator = Number of incidents where the provider's CAP includes strategies to mitigate/prevent future incidents. Denominator = All investigated incidents where the provider is required to develop a CAP.~~ **HW3: Number and percent of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame. Numerator = Number of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame. Denominator = All critical incidents, by type of incident.** Data Source (Select one): Other If 'Other' is selected, specify: Enterprise Incident Management (EIM)~~and IM spreadsheet~~ Performance Measure ~~PS4~~ **HW4**: Number and percent of ~~participants with a~~ confirmed incident**s** ~~which are~~ reported and reviewed at quarterly risk management meetings to determine any patterns related to participants or providers. Numerator = ~~Participants with a~~ **Number of** confirmed incident**s**	These changes were made to align with the ID/A waivers.

	Other If 'Other' is selected, specify: **Provider Monitoring**	~~which are~~ reported ~~to~~ **and reviewed at** quarterly risk management meetings. Denominator = All confirmed incidents. Data Source (Select one): Other If 'Other' is selected, specify: ~~Provider Monitoring~~ **EIM**	
G-a.i.c	**Performance Measure PS5: Number and percent of incidents related to restrictive interventions where BAS policies and procedures were followed. Numerator = Number of incidents related to restrictive interventions where BAS policies and procedures were followed. Denominator = Number of incidents related to restrictive interventions.**	Performance Measure~~ PS5~~ **HW5**: Number and percent of ~~incidents related to~~ **participants with** restrictive interventions where ~~BAS policies and~~ **proper** procedures were followed. Numerator = Number of ~~incidents related to~~ **participants with** restrictive interventions where ~~BAS policies and~~ **proper** procedures were followed. Denominator = Number of ~~incidents related to~~ **participants with a** restrictive intervention~~s~~ **plan reviewed**.	These changes were made to align with the ID/A waivers.
G-a.i.d	**Performance Measure PS6: Number of percent of participants who reported that they are able to receive medical attention as needed. Numerator = Number of participants who reported that they are able to receive medical attention as needed. Denominator = Number of participants interviewed.** **Data Source** (Select one): **Other** If 'Other' is selected, specify: **Participant interviews**	Performance Measure~~ PS6~~ **HW6**: Number ~~of~~ **and** percent of participants ~~who reported that they are able to receive medical attention as needed.~~ **whose identified healthcare needs are being addressed.** Numerator = Number of participants ~~who reported that they are able to receive medical attention as needed~~ **whose identified healthcare needs are being addressed**. Denominator = Number of participants ~~interviewed~~ **reviewed**. Data Source (Select one): Other If 'Other' is selected, specify: ~~Participant interviews~~**Participant Record Review**	These changes were made to align with the ID/A waivers.
G-a.ii	If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. As described in Appendix D-2-a. Supports Coordinators must contact the participant at least each month and visit the participant in-person at least each quarter. Within each year, at least one visit must occur in the participant's home and one visit must occur in a location outside the home where a participant receives services. Supports Coordinators enter monitoring findings in HCSIS. The monitoring includes: • Observing whether the participant feels healthy and not in pain or injured;	If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. ~~As described in Appendix D-2-a. Supports Coordinators must contact the participant at least each month and visit the participant in-person at least each quarter. Within each year, at least one visit must occur in the participant's home and one visit must occur in a location outside the home where a participant receives services. Supports Coordinators enter monitoring findings in HCSIS. The monitoring includes:~~ ~~• Observing whether the participant feels healthy and not in pain or injured;~~	These changes were made to align with the ID/A waivers.

	• Interviewing the participant and others to identify any concerns regarding the participant's health and welfare; • Reviewing the participant's progress toward goals; and • Assessing the effectiveness of back-up plans. BAS staff will review Supports Coordinator monitoring notes in HCSIS for certain participants. BAS conducts these reviews on a quarterly basis for participants who exhibited very serious or extremely serious challenging behaviors according to the most recent SIB-R assessment, or who have experienced a crisis episode in the past year. All incidents are reported in EIM – or, if EIM is unavailable, via e-mail of password protected files as described in Appendix G-1-b. Each month, BAS generates reports regarding critical incidents. One report lists the participants that had a reported incident, the incident date and location, the type of incident, and status of investigation (if required). A second report shows similar information, but is organized by provider so BAS staff can quickly identify providers with an unusually high number of incidents. The third report shows the number of incidents by type of incident. All confirmed incidents of abuse, neglect or exploitation are reported and reviewed at quarterly risk management meetings to identify patterns of recurrence or risk by participants or providers. When such patterns are identified, BAS will contact the supports coordinator, the participant, the provider(s) or other individuals as appropriate to determine necessary follow-up actions to reduce the risk of recurrence.	~~• Interviewing the participant and others to identify any concerns regarding the participant's health and welfare;~~ ~~• Reviewing the participant's progress toward goals; and~~ ~~• Assessing the effectiveness of back-up plans.~~ ~~BAS staff will review Supports Coordinator monitoring notes in HCSIS for certain participants. BAS conducts these reviews on a quarterly basis for participants who exhibited very serious or extremely serious challenging behaviors according to the most recent SIB-R assessment, or who have experienced a crisis episode in the past year.~~ ~~All incidents are reported in EIM – or, if EIM is unavailable, via e-mail of password protected files as described in Appendix G-1-b. Each month, BAS generates reports regarding critical incidents. One report lists the participants that had a reported incident, the incident date and location, the type of incident, and status of investigation (if required). A second report shows similar information, but is organized by provider so BAS staff can quickly identify providers with an unusually high number of incidents. The third report shows the number of incidents by type of incident.~~ ~~All confirmed incidents of abuse, neglect or exploitation are reported and reviewed at quarterly risk management meetings to identify patterns of recurrence or risk by participants or providers. When such patterns are identified, BAS will contact the supports coordinator, the participant, the provider(s) or other individuals as appropriate to determine necessary follow-up actions to reduce the risk of recurrence.~~	
G-b.i-ii	**Methods for Remediation/Fixing Individual Problems** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. As described in Appendix D-2-a, if at any point the Supports Coordinator believes that a participant's health and welfare is in jeopardy, he or she will take immediate action to assure the person's safety. When a Supports Coordinator identifies a less serious issue, he or she must work with the	Methods for Remediation/Fixing Individual Problems Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. ~~As described in Appendix D-2-a, if at any point the Supports Coordinator believes that a participant's health and welfare is in jeopardy, he or she will take immediate action to assure the person's safety. When a Supports Coordinator identifies a less serious issue, he or she must work with the~~	These changes were made to align with the ID/A waivers.

	participant, informal supports, and other service providers to address the issue. If BAS identifies any concerns regarding health and welfare when reviewing Supports Coordination quarterly monitoring, BAS staff will provide support or technical assistance to the Supports Coordinator to help resolve the situation. When necessary, the Supports Coordinator will reconvene the planning team to revise the ISP. BAS staff may also contact the participant and/or other service providers as necessary to ensure participant health and welfare. **ii. Remediation Data Aggregation** **Frequency of data aggregation and analysis** *(check each that applies)*: **Monthly**	~~participant, informal supports, and other service providers to address the issue.~~ ~~If BAS identifies any concerns regarding health and welfare when reviewing Supports Coordination quarterly monitoring, BAS staff will provide support or technical assistance to the Supports Coordinator to help resolve the situation. When necessary, the Supports Coordinator will reconvene the planning team to revise the ISP. BAS staff may also contact the participant and/or other service providers as necessary to ensure participant health and welfare.~~ **HW2. Number and percent of participants who received information about reporting abuse, neglect, and exploitation. ODP reviews a sample of participant 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, ODP will direct the SC to follow-up with the participant and his or her family to provide the necessary information. The SC will use the service plan Signature Form to document that information about reporting abuse, neglect, and exploitation was offered as well as to document the date follow-up occurred. Documentation of remediation actions is expected to be submitted to ODP by the SCO within 30 days of notification.** **HW4. All confirmed incidents of abuse, neglect or exploitation are reported and reviewed at quarterly risk management meetings to identify patterns of recurrence or risk by participants or providers. When such patterns are identified, ODP will contact the SC, the participant, the provider(s) or other individuals as appropriate to determine necessary follow-up actions to reduce the risk of recurrence.** **HW6. Number and percent of participants whose identified health care needs are being addressed. Using the sample of waiver participants, ODP reviews monitoring conducted by the participant's SC. The ODP standardized individual monitoring tool includes questions evaluating whether identified health care needs are addressed as specified in the service plan. In any instance where the SC identifies a concern regarding addressing identified health care needs, and the issue remains unresolved, ODP will work with the**	

		SCO to resolve the situation. Resolution can include but is not limited to resumption of services at the required frequency, additional assessment by the current service provider, pursuit of a second opinion/consultation from an alternate provider, changes in service provider, team meetings, or changes in service schedule. The SCO will provide documentation of the resolution to ODP. Remediation is expected to occur within 30 days of notification. ii. Remediation Data Aggregation Frequency of data aggregation and analysis *(check each that applies)*: ~~Monthly~~ **X Quarterly** **X Annually**	
Appendix H			
H-1.a	a. **System Improvements** i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information. Within four months of the end of each State Fiscal Year (each October), BAS Central Office will produce an Annual Quality Assurance Report with a summary of findings and corrective action from all quality management activities described in the waiver application. The primary audience for both reports is the public, including people with ASD, advocacy groups, and providers. The report will be posted on the DHS Web site and available to the public. Based on information from the annual reports, the BAS Director will set priorities regarding quality improvement activities each year. In addition, BAS Central Office leads quarterly Quality Management meetings attended by the supervisors of each BAS Regional Office. These meetings focus on reviewing aggregated provider and participant monitoring data, designing improvement projects to respond to identified needs for remediation, and tracking progress on completion and effectiveness of improvement projects. Specific to assuring health and safety, BAS staff will meet quarterly regarding risk management. The meetings will include a representative from the BAS Central Office, each BAS Regional Office, and the BAS clinical team. Before each meeting, BAS will review monthly incident report data and the results of	a. System Improvements i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information. ~~Within four months of the end of each State Fiscal Year (each October), BAS Central Office will produce an Annual Quality Assurance Report with a summary of findings and corrective action from all quality management activities described in the waiver application. The primary audience for both reports is the public, including people with ASD, advocacy groups, and providers. The report will be posted on the DHS Web site and available to the public. Based on information from the annual reports, the BAS Director will set priorities regarding quality improvement activities each year.~~ **ODP selects for review a proportionate, representative, random sample of waiver participants, using a confidence level of 90% and margin of error of 10%. The results obtained reflect how the AAW system is performing and if it is responsive to the needs of the participants served. ODP trends, prioritizes and implements system improvements (i.e., design changes) prompted as a result of an analysis of the discovery and remediation information obtained across each of the waiver assurance areas.** ~~In addition, BAS Central Office~~ **ODP** leads quarterly Quality Management meetings attended by the supervisors of each B**S**AS**P** Regional Office. These	These changes were made to align with the ID/A waivers.

	monitoring of Supports Coordinator notes for participants who have exhibited "very serious" or "extremely serious" challenging behaviors, or who have experienced a crisis event in the past quarter. BAS staff will analyze the data from that quarter and previous quarters to identify statewide and regional trends by incident type, by participant, and by provider. During the meeting, staff will discuss identified trends, identify possible causes, and specify next steps for reducing participants' risk of abuse, neglect, or exploitation.	meetings focus on reviewing aggregate~~d~~ provider and participant monitoring data, designing improvement projects to respond to identified needs ~~for remediation~~, and tracking progress on completion and effectiveness of **these** ~~improvement~~ projects. Specific to assuring health and safety, ~~BAS~~**ODP** staff ~~will~~ meet quarterly regarding risk management. The meetings ~~will~~ include a representative from the B**S**AS**P** Central Office, each B**S**AS**P** Regional Office, and the B**S**AS**P** clinical team. Before each meeting, ~~BAS~~ **ODP** ~~will~~ review**s** monthly incident report data and the results of monitoring of Supports Coordinator notes for participants who have exhibited "very serious" or "extremely serious" challenging behaviors, or who have experienced a crisis event in the past quarter. ~~BAS~~ **ODP** staff ~~will~~ analyze the data from that quarter and previous quarters to identify statewide and regional trends by incident type, by participant, and by provider. During the meeting, staff ~~will~~ discuss identified trends, identify possible causes, and specify next steps for reducing participants' risk of abuse, neglect, or exploitation. **ODP assigns staff to implement quality improvements based on the scope of the design change and the expertise required. ODP involves additional stakeholders including AEs, providers, supports coordination organizations, individuals served and their families, and other State agencies based on the design change involved and specific input needed.** **Recommendations for action are also identified by ODP's Information Sharing and Advisory Committee (ISAC). The ISAC serves as ODP's stakeholder quality council. ODP prioritizes opportunities for system improvements in conjunction with the ISAC, then disseminates these priorities to the field. Stakeholders representing their constituencies on the ISAC are expected to collaborate with ODP in the implementation, monitoring and evaluation of changes designed to achieve system improvements using a data-based approach.**	
H-1.b	b. **System Design Changes** i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system	b. System Design Changes i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system	These changes were made to align with the ID/A waivers.

	design changes. If applicable, include the State's targeted standards for systems improvement. BAS will monitor system design changes on an annual basis and during quarterly Quality Management meetings as described in Appendix H.1.a.i. When system design changes are made, BAS will specify discovery activities and measures specific to the particular design change to evaluate the effect of the changes. BAS will then include the results in the Annual Quality Assurance Report. These reports will be communicated as described in Appendix H.1.a.i. ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy. On an annual basis, BAS will evaluate the quality improvement strategy related to provider and participant monitoring. Once the annual monitoring cycle is completed, BAS reviews and analyzes the collected data to determine whether additional or improved tools or strategies are required for the next monitoring cycle. For quality issues not related to provider and participant monitoring, BAS holds quarterly Quality Management meetings to review and analyze data related to the day-to-day performance of the waiver. When weaknesses are identified, BAS staff develop improvement projects to address them. Before submission of a waiver renewal application, BAS solicits feedback from all waiver stakeholders on the waiver application as a whole, which includes the proposed quality improvement strategy. Stakeholder comments are considered prior to submission of the application. BAS will work internally to draft suggested revisions of the quality improvement strategy, if any. BAS will then release a draft revision of the quality improvement strategy on the DHS Web site, noting any changes and BAS will solicit public comment from all interested parties. BAS will provide notice of changes to the quality improvement strategy through publication in the Pennsylvania Bulletin, distribution to BAS's provider listservs, advocacy organizations, support groups, and the Autism Services, Education, Resources and Training Collaborative (ASERT), an initiative funded by BAS that provides streamlined access to information to individuals with autism and those who support them. BAS will consider comments from stakeholders and then	design changes. If applicable, include the State's targeted standards for systems improvement. When system design changes are made, ~~BAS~~ **ODP** ~~will~~ specif~~y~~**ies** discovery activities and measures specific to the particular design change to evaluate the effect of the changes. ~~BAS~~ **ODP** ~~will~~ monitor**s these** system design changes ~~on an annual basis and~~ during quarterly Quality Management **and risk management** meetings **and on an annual basis.** ~~as described in Appendix H.1.a.i. BAS will then include the results in the Annual Quality Assurance Report. These reports will be communicated as described in Appendix H.1.a.i.~~ **ODP produces an Annual Quality Assurance Report with a summary of findings and corrective action from its review of performance across each of the waiver assurance areas from a sample of waiver participants. The primary audience for this report is the public, including people with ASD, advocacy groups, and providers. The report is posted on the DHS Web site.** ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy. ~~On an annual basis, BAS will evaluate the quality improvement strategy related to provider and participant monitoring. Once the annual monitoring cycle is completed, BAS reviews and analyzes the collected data to determine whether additional or improved tools or strategies are required for the next monitoring cycle. For quality issues not related to provider and participant monitoring, BAS holds quarterly Quality Management meetings to review and analyze data related to the day-to-day performance of the waiver. When weaknesses are identified, BAS staff develop improvement projects to address them. Before submission of a waiver renewal application, BAS solicits feedback from all waiver stakeholders on the waiver application as a whole, which includes the proposed quality improvement strategy. Stakeholder comments are considered prior to submission of the application.~~ ~~BAS will work internally to draft suggested revisions of the quality improvement strategy, if any. BAS will then release a draft revision of the quality improvement strategy on the DHS Web site, noting any changes and~~	

	release a final quality improvement strategy before submitting a waiver renewal to CMS during the fifth year of the waiver renewal (2021).	~~BAS will solicit public comment from all interested parties. BAS will provide notice of changes to the quality improvement strategy through publication in the Pennsylvania Bulletin, distribution to BAS's provider listservs, advocacy organizations, support groups, and the Autism Services, Education, Resources and Training Collaborative (ASERT), an initiative funded by BAS that provides streamlined access to information to individuals with autism and those who support them. BAS will consider comments from stakeholders and then release a final quality improvement strategy before submitting a waiver renewal to CMS during the fifth year of the waiver renewal (2021).~~ **On an annual basis, considering input from Quality Management meetings and the ISAC, ODP's Executive Staff assesses program and operational performance as well as ODP's Quality Management Strategy (QMS). Results of this review may demonstrate a need to revise ODP's QMS, including changing priorities, using different approaches to ensure progress, modifying roles and responsibilities of key entities, and modifying data sources in order to retrieve the information needed for measurement.**	
Appendix I			
I-1	**Financial Integrity.** (f) For a random sample of participants, as part of the annual monitoring of providers, BAS compares paid claims data to provider records such as time sheets and reports of services rendered. This review is described in the Performance Measure for Appendix I. This review is an on-site, manual comparison of a provider's records to a report of paid claims from PROMISe, the state's Medicaid Management Information System. BAS reviews for consistency of day and time between the documentation and the claim as well as documentation supporting the number of units billed. The review occurs each year for the providers serving the sample of participants, claims will be reviewed sufficient for a 95% confidence interval with 5% margin of error. The providers who are currently serving the participants in the monitoring sample will have claims reviewed for a 95% confidence interval with a 5% margin of error by randomly selecting claims from the previous fiscal year across all participants served.	Financial Integrity. (f)~~ For a random sample of participants, as part of the annual monitoring of provider~~s, **Providers are reviewed by ODP through the Quality Assessment and Improvement (QA&I) process on a 3-year cycle**. ~~BAS~~ **ODP** compares paid claims data to provider records such as time sheets and reports of services rendered **for a random selection of claims from the previous fiscal year across all participants served**. This review is described in the Performance Measure for Appendix I. This ~~review~~ is **a desk review comparing** ~~an on-site, manual comparison of~~ a provider's records to a report of paid claims from PROMISe, the state's Medicaid Management Information System. ~~BAS~~ **ODP** reviews for consistency of day and time between the documentation and the claim as well as documentation supporting the number of units billed. ~~The review occurs each year for the providers serving the sample of participants, claims will reviewed sufficient for a 95% confidence interval with 5% margin of error.~~ The providers **identified** ~~who are currently serving the participants~~ in the monitoring sample **each year** will have claims reviewed for a 95% confidence	These changes were made to align with the ID/A waivers.

	o Process to review findings, establish priorities, and develop remediation and improvement strategies, including roles and responsibilities (in addition to the overall process described in the Overview): If BAS staff suspect inappropriate billing based on its monitoring, BAS staff will review the provider history through HCSIS and PROMISe reports and complete an investigation which may include additional review of services rendered reports, time sheets, and claims to determine if inaccurate or inappropriate billings were submitted. Depending upon the findings of the review, remediation may require: o BAS monitoring and training of provider staff in documentation of services rendered; o A time-limited monitoring by BAS or provider supervisor of weekly time sheets submitted by staff o Suspension of new enrollment o Termination of contract o Requiring the provider to refund inappropriately billed amounts In any of the above situations, if the findings result in suspected fraud or abuse, BAS will report the provider staff or individual staff person to the DHS, Office of Administration (OA) Bureau of Program Integrity (BPI) for appropriate investigation and legal action as necessary. BAS conducts post-payment review of billing of all providers included in annual monitoring activities. Providers determined to be high or medium risk are referred to the Bureau of Financial Operations (BFO). For provider's determined low risk, BAS works with the provider to find the appropriate resolution to the issues found and remediate to avoid repetition in the future. The DHS BFO accepts recommendations from the program offices for audit. These are usually providers that are not meeting the standards set forth within the PA Title 55 Regulations. The BFO will then conduct research on the party/program to be audited. Generally, audits are conducted on the entities recommended by the program offices. This is primarily based on the program office's suspicion or evidence of fraud and or abuse. The BFO conducts an independent risk analysis of the Home and Community Based Services program. The criteria used are the various attributes of claims submitted to	interval with a 5% margin of error by randomly selecting claims from the previous fiscal year across all participants served. o Process to review findings, establish priorities, and develop remediation and improvement strategies, including roles and responsibilities (in addition to the overall process described in the Overview): If ~~BAS~~ **ODP** staff suspect inappropriate billing based on its monitoring, ~~BAS~~ **ODP** staff will review the provider history through HCSIS and PROMISe reports and complete an investigation which may include additional review of services rendered reports, time sheets, and claims to determine if inaccurate or inappropriate billings were submitted. Depending upon the findings of the review, remediation may require: o ~~BAS~~ **ODP** monitoring and training of provider staff in documentation of services rendered; o A time-limited monitoring by ~~BAS~~ **ODP** or provider supervisor of weekly time sheets submitted by staff**;** o Suspension of new enrollment**;** o Termination of contract**;** o Requiring the provider to refund inappropriately billed amounts**.** In any of the above situations, if the findings result in suspected fraud or abuse, ~~BAS~~ **ODP** will report the provider staff or individual staff person to the DHS, Office of Administration (OA) Bureau of Program Integrity (BPI) for appropriate investigation and legal action as necessary. ~~BAS~~ **ODP** conducts post-payment review of billing of all providers included in annual monitoring activities. Providers determined to be high or medium risk are referred to the Bureau of Financial Operations (BFO). For provider~~'~~s determined low risk, ~~BAS~~ **ODP** works with the provider to find the appropriate resolution to the issues found and remediate to avoid repetition in the future. The ~~DHS~~ BFO accepts recommendations from the program offices for audit. These are usually providers that are not meeting the standards set forth within the PA Title 55 Regulations. The BFO will then conduct research on the party/program to be audited. Generally, audits are conducted on the entities	

	DHS for PROMISe payments. These may be the number of claims submitted for a period, the total value of claims submitted for a period, procedure codes or time in program providing audit-identified services. Also, the BFO may identify an entity to be audited based on work conducted at other entities or government agencies. Risk is categorized as high, moderate or low. Types of risk could be both known and/or unknown. Audits are usually selected based on known risks. Types of risks that factor into audit selection are: • Potential for fraud • Compliance with laws, regulations, etc. • Controls (internal and external) • Provider size • Volume and value of claims • Complaints • Documentation of service delivery o The type, method, and frequency of BAS post-payment reviews that ensure the adequacy and the integrity of payments: In addition to the audits described above, BAS compares paid claims data to provider records such as time sheets and reports of services rendered for a random sample of participants. This review is described in the Performance Measure for Appendix I. This review is an on-site, manual comparison of a provider's records to a report of paid claims from PROMISe, the state's Medicaid Management Information System. BAS reviews for consistency of day and time between the documentation and the claim as well as documentation supporting the number of units billed. The review occurs each year for a sample of participants sufficient for a 95% confidence internal with 5% margin of error. The providers who are currently serving the participants in the monitoring sample will have claims reviewed for a 95% confidence internal with a 5% margin of error by randomly selecting claims from the previous fiscal year across all participants served.	recommended by the program offices. This is primarily based on the program office's suspicion or evidence of fraud and or abuse. The BFO conducts an independent risk analysis of the Home and Community Based Services program. The criteria used are the various attributes of claims submitted to DHS for PROMISe payments. These may be the number of claims submitted for a period, the total value of claims submitted for a period, procedure codes or time in program providing audit-identified services. Also, the BFO may identify an entity to be audited based on work conducted at other entities or government agencies. Risk is categorized as high, moderate or low. Types of risk could be both known and/or unknown. Audits are usually selected based on known risks. Types of risks that factor into audit selection are: • Potential for fraud • Compliance with laws, regulations, etc. • Controls (internal and external) • Provider size • Volume and value of claims • Complaints • Documentation of service delivery o The type, method, and frequency of ~~BAS~~ **ODP** post-payment reviews that ensure the adequacy and the integrity of payments: ~~In addition to the audits described above, BAS compares paid claims data to provider records such as time sheets and reports of services rendered for a random sample of participants. This review is described in the Performance Measure for Appendix I. This review is an on-site, manual comparison of a provider's records to a report of paid claims from PROMISe, the state's Medicaid Management Information System. BAS reviews for consistency of day and time between the documentation and the claim as well as documentation supporting the number of units billed. The review occurs each year for a sample of participants sufficient for a 95% confidence internal with 5% margin of error.~~	

	(Language purposely omitted. Please see approved Adult Autism Waiver for full language.) Annual provider monitoring includes a review of provider records for each participant in the random sample. During provider monitoring, BAS staff review documentation that substantiates that each service was provided as billed. If there is not adequate documentation or the monitor suspects' inappropriate billing, an expanded review will be initiated. For findings of noncompliance, a plan of correction is required and the inadequate billing would be adjusted or voided in PROMISe. If the provider is noncompliant with the plan of correction, or the BAS monitor discovers the provider is significantly out of compliance, the case is referred to BFO for an in-depth audit. BAS verifies qualifications of every provider for each of the services for which they are enrolled on a biennial basis. In addition, providers supporting participants included in the annual monitoring of a statistically representative sample are also monitored for qualifications, compliance with requirements and billing.	~~The providers who are currently serving the participants in the monitoring sample will have claims reviewed for a 95% confidence internal with a 5% margin of error by randomly selecting claims from the previous fiscal year across all participants served.~~ ~~Annual provider monitoring includes a review of provider records for each participant in the random sample. During provider monitoring, BAS staff review documentation that substantiates that each service was provided as billed. If there is not adequate documentation or the monitor suspects' inappropriate billing, an expanded review will be initiated. For findings of noncompliance, a plan of correction is required and the inadequate billing would be adjusted or voided in PROMISe. If the provider is noncompliant with the plan of correction, or the BAS monitor discovers the provider is significantly out of compliance, the case is referred to BFO for an in-depth audit.~~ ~~BAS verifies qualifications of every provider for each of the services for which they are enrolled on a biennial basis. In addition, providers supporting participants included in the annual monitoring of a statistically representative sample are also monitored for qualifications, compliance with requirements and billing.~~	
I-2-a	**Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable). Providers are reimbursed on a statewide fee for service basis for Specialized Skill Development, Day Habilitation, Family Support, Career Planning, Nutritional Consultation, Residential Habilitation, Respite, Supported Employment, Supports Coordination, Temporary Supplemental Services, Therapies and Transitional Work Services. The rates for this program are published for all providers. The fee schedule has no regional variation. There is	Rate Determination Methods**.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable). **Services in the Adult Autism Waiver are paid based on a Medical Assistance fee schedule or on invoice costs for vendor services.** **Medical Assistance (MA) Fee Schedule:** **MA fee schedule rates are developed using a market-based approach. This process includes a review of the service definitions and a determination of**	These changes were made to align with the ID/A waivers.

	no cost settlement. The state does not use other funding sources to compute budget neutrality. BAS pays for waiver services based on a fee schedule, and the fees are developed using a market-based approach. Assumptions for supervisory staff, occupancy, indirect costs and administration costs are developed based on program requirements and each represent different costs that a provider would incur in delivering the service. The assumptions for these items do not include duplicative activities or costs. For Assistive Technology, Community Transition Services, Home Modifications, and Vehicle Modifications**,** providers are reimbursed at the invoice cost for the service or equipment provided. Total costs may not exceed limits in Appendix C-3 for each service. PROMISe™ checks claims against any applicable limitations to ensure the total costs do not exceed the service limits in Appendix C-3. When a participant is assessed, either initially or annually, their need for assistive technology, community transition services, and home or vehicle modifications is made. The approved assistive technology, community transition services, and home and vehicle modifications are placed on the participant's service plan. The participant's Supports Coordinator locates the services from qualified providers and equipment from qualified vendors and arranges for the participant to receive training to be able to use it (for equipment) and receives feedback from the family or representative (for the community transition services and home or vehicle modifications). BAS contracted with Mercer Government Human Services Consulting (Mercer) from May to August 2015 to review the fee schedule rates for all existing and proposed services and service components for those services that are paid based on a statewide fee schedule. In developing payment rates for these services, Mercer's methodology contained an analysis of four key components: --direct care salary expenses, --employee related expenses, --program expenses and	**allowable cost components which reflect costs that are reasonable, necessary and related to the delivery of the service, as defined in Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (OMB Circular Uniform Guidance, December 26, 2014). ODP establishes the fee schedule rates to fund services at a level sufficient to ensure access, encourage provider participation and promote provider choice, while at the same time ensuring cost effectiveness and fiscal accountability. The fee schedule rates represent the maximum rates that ODP will pay for each service.** **ODP develops rates for each of the MA fee schedule services using the following process. ODP:** **• Reviews wage data provided by the Bureau of Labor Statistics to develop service-specific wage rates based on the staffing requirements and roles and responsibilities of the worker. This component is the most significant portion of the total payment rate.** **• Considers the expected expenses for the delivery of the services under the waiver for the following major allowable cost categories:** **- The support needs of the participants** **- Staff wages** **- Staff-related expenses** **- Productivity** **- Occupancy** **- Program expenses and administration-related expenses** **- A review of approved service definitions in the waiver and determinations made about cost components that reflect costs necessary and related to the delivery of each service** **- A review of the cost of implementing Federal, State and local statutes, regulations and ordinances.** Providers are reimbursed on a statewide fee for service basis for Specialized Skill Development, Day Habilitation, Family Support, Career Planning, Nutritional Consultation, Residential Habilitation, Respite, Supported Employment, Supports Coordination, Temporary Supplemental Services, Therapies**,** ~~and Transitional Work Services~~ **Small Group Employment and Transportation-Trip**. ~~The rates for this program are published for all providers.~~	

	--administrative expenses. Mercer conducted a compensation study to determine the appropriate wage or salary expense for the direct care workers providing each service. Mercer reviewed wage data provided by the Bureau of Labor Statistics to develop service-specific wage rates based on the staffing requirements and roles and responsibilities of the worker. This component is the most significant portion of the total payment rate. In developing the other three rate components, Mercer and BAS first discussed the allowable costs to be funded through each service and included only allowable program and administrative expenses. Mercer used this information to develop rates that comply with the requirements of Section 1902(a)30(A) of the Social Security Act (i.e., payments are consistent with economy, efficiency and quality of care and are sufficient to enlist enough providers) and the related federal regulations at 42 CFR 447.200 205. BAS reviews provider enrollment and retention for each service annually to ensure that access to care and adequacy of payments are maintained. There are only two reasons rates may vary for different providers of the same service: 1. For services where there are different rates by level such as Residential Habilitation, Day Habilitation, and Transitional Work, all providers who deliver a service at the same level are paid the same rate. 2. Rates for Assistive Technology, Community Transition Services, Home Modifications, and Vehicle Modifications vary based on the invoice cost of the particular items. In accordance with 42 CFR 441.310(a)(2), FFP is not claimed for room and board costs except as part of respite services when provided in a licensed or certified respite facility and not a private residence. Room and board costs are not included in the rates for any of the other services.	~~The fee schedule has no regional variation. There is no cost settlement. The state does not use other funding sources to compute budget neutrality.~~ ~~BAS pays for waiver services based on a fee schedule, and the fees are developed using a market-based approach.~~ ~~Assumptions for supervisory staff, occupancy, indirect costs and administration costs are developed based on program requirements and each represent different costs that a provider would incur in delivering the service. The assumptions for these items do not include duplicative activities or costs.~~ ~~For Assistive Technology, Community Transition Services, Home Modifications, and Vehicle Modifications, providers are reimbursed at the invoice cost for the service or equipment provided. Total costs may not exceed limits in Appendix C-3 for each service.~~ ~~PROMISe™ checks claims against any applicable limitations to ensure the total costs do not exceed the service limits in Appendix C-3. When a participant is assessed, either initially or annually, their need for assistive technology, community transition services, and home or vehicle modifications is made. The approved assistive technology, community transition services, and home and vehicle modifications are placed on the participant's service plan. The participant's Supports Coordinator locates the services from qualified providers and equipment from qualified vendors and arranges for the participant to receive training to be able to use it (for equipment) and receives feedback from the family or representative (for the community transition services and home or vehicle modifications).~~ ~~BAS contracted with Mercer Government Human Services Consulting (Mercer) from May to August 2015 to review the fee schedule rates for all existing and proposed services and service components for those services that are paid based on a statewide fee schedule. In developing payment rates for these services, Mercer's methodology contained an analysis of four key components:~~ ~~--direct care salary expenses,~~ ~~--employee related expenses,~~ ~~--program expenses and~~ ~~--administrative expenses.~~	

	BAS made the rates available to waiver participants, providers and the public through the DHS Web site and publication in The Pennsylvania Bulletin. If a change in the methodology occurs, BAS will amend the waiver and provide CMS with the updated methodology, as well as publish the change in The Pennsylvania Bulletin. The OMAP reimburses qualified providers through the Medicaid Management Information System, called the Provider Reimbursement and Operations Management Information System (PROMISe). Payments are made directly to the provider of record. BAS reviews provider enrollment and retention for each service annually to ensure that access to care and adequacy of payments are maintained. The BAS has staff that continuously focuses on recruiting and enrolling providers based on provider interest and areas of greatest need geographically to ensure participant choice. As the program grows, the BAS expects to increase the pool of providers to provide meaningful choice among providers to meet the needs of multiple participants in each county. The BAS reviews the AAW Provider Enrollment database on an annual basis, to ensure that all providers' qualifications have been verified as specified in the approved waiver.	~~Mercer conducted a compensation study to determine the appropriate wage or salary expense for the direct care workers providing each service. Mercer reviewed wage data provided by the Bureau of Labor Statistics to develop service-specific wage rates based on the staffing requirements and roles and responsibilities of the worker. This component is the most significant portion of the total payment rate.~~ ~~In developing the other three rate components, Mercer and BAS first discussed the allowable costs to be funded through each service and included only allowable program and administrative expenses.~~ ~~Mercer used this information to develop rates that comply with the requirements of Section 1902(a)30(A) of the Social Security Act (i.e., payments are consistent with economy, efficiency and quality of care and are sufficient to enlist enough providers) and the related federal regulations at 42 CFR 447.200 205. BAS reviews provider enrollment and retention for each service annually to ensure that access to care and adequacy of payments are maintained.~~ ~~There are only two reasons rates may vary for different providers of the same service:~~ ~~1. For services where there are different rates by level such as Residential Habilitation, Day Habilitation, and Transitional Work, all providers who deliver a service at the same level are paid the same rate.~~ ~~2. Rates for Assistive Technology, Community Transition Services, Home Modifications, and Vehicle Modifications vary based on the invoice cost of the particular items.~~ ~~In accordance with 42 CFR 441.310(a)(2), FFP is not claimed for room and board costs except as part of respite services when provided in a licensed or certified respite facility and not a private residence. Room and board costs are not included in the rates for any of the other services.~~	

		~~BAS made the rates available to waiver participants, providers and the public through the DHS Web site and publication in The Pennsylvania Bulletin. If a change in the methodology occurs, BAS will amend the waiver and provide CMS with the updated methodology, as well as publish the change in The Pennsylvania Bulletin.~~ ~~The OMAP reimburses qualified providers through the Medicaid Management Information System, called the Provider Reimbursement and Operations Management Information System (PROMISe). Payments are made directly to the provider of record.~~ ~~BAS reviews provider enrollment and retention for each service annually to ensure that access to care and adequacy of payments are maintained. The BAS has staff that continuously focuses on recruiting and enrolling providers based on provider interest and areas of greatest need geographically to ensure participant choice. As the program grows, the BAS expects to increase the pool of providers to provide meaningful choice among providers to meet the needs of multiple participants in each county. The BAS reviews the AAW Provider Enrollment database on an annual basis, to ensure that all providers' qualifications have been verified as specified in the approved waiver.~~ **Changes to the fee schedule are communicated through a public notice published in the Pennsylvania Bulletin prior to the effective date of any change or addition. Fee schedule rates are implemented prospectively.** **Vendor Goods and Services: For Assistive Technology, Community Transition Services, Transportation (Public), Home Modifications, and Vehicle Modifications, providers are reimbursed at the invoice cost for the service or equipment provided. DHS reimburses those services based on the cost charged to the general public for the service or equipment.** **Total costs may not exceed the limits in Appendix C-3 for each service unless an exception to the limit is requested of and approved by ODP.**	
I-2-d	**Billing Validation Process**. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when	Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when	These changes were made to align

	the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided: Many County Mental Health and Individuals with an Intellectual Disability (MH/IID) Programs have experience working with people who have autism spectrum disorders as well as a mental illness or mental retardation diagnosis. A County MH/IID agency can enroll for any service for which the organization meets the qualifications in Appendix C-3. Services listed in the waiver are Assistive Technology, Specialized Skill Development, Career Planning, Community Transition Services, Day Habilitation, Home Modifications, Vehicle Modifications, Family Support, Career Planning, Nutritional Consultation, Residential Habilitation, Respite, Supported Employment, Supports Coordination, Temporary Supplemental Services, Therapies, and Transitional Work Services. The process for counties is the same as for all other providers. During the provider application process, the BAS staff determines whether the provider meets the provider qualification criteria outlined in this waiver. If the provider meets the criteria, the BAS notifies the Office of Medical Assistance Programs (OMAP), that the provider has been determined qualified by BAS. OMAP then authorizes that provider to be added to ISPs of AAW participants and to bill against the AAW. The BAS reviews provider qualifications at least biennially. If findings from discovery activities indicate a provider does not meet provider standards, the BAS will contact the provider for more information to assess whether the provider meets standards. If a provider does not meet provider standards, the BAS will give the provider 30 days to remediate the reason for ineligibility. The BAS will provide technical assistance and training to the provider during this time to prevent disenrollment and will advise the supports coordinator that the provider may be dis-enrolled. If the provider does not meet provider standards after 30 days, the BAS will dis-enroll the provider and notify the supports coordinator that participants will need to identify a new provider. The supports coordinator will notify the participant that a new provider is	~~the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:~~ ~~Many County Mental Health and Individuals with an Intellectual Disability (MH/IID) Programs have experience working with people who have autism spectrum disorders as well as a mental illness or mental retardation diagnosis.~~ ~~A County MH/IID agency can enroll for any service for which the organization meets the qualifications in Appendix C-3. Services listed in the waiver are Assistive Technology, Specialized Skill Development, Career Planning, Community Transition Services, Day Habilitation, Home Modifications, Vehicle Modifications, Family Support, Career Planning, Nutritional Consultation, Residential Habilitation, Respite, Supported Employment, Supports Coordination, Temporary Supplemental Services, Therapies, and Transitional Work Services.~~ ~~The process for counties is the same as for all other providers. During the provider application process, the BAS staff determines whether the provider meets the provider qualification criteria outlined in this waiver. If the provider meets the criteria, the BAS notifies the Office of Medical Assistance Programs (OMAP), that the provider has been determined qualified by BAS. OMAP then authorizes that provider to be added to ISPs of AAW participants and to bill against the AAW.~~ ~~The BAS reviews provider qualifications at least biennially. If findings from discovery activities indicate a provider does not meet provider standards, the BAS will contact the provider for more information to assess whether the provider meets standards. If a provider does not meet provider standards, the BAS will give the provider 30 days to remediate the reason for ineligibility. The BAS will provide technical assistance and training to the provider during this time to prevent disenrollment and will advise the supports coordinator that the provider may be dis-enrolled. If the provider does not meet provider standards after 30 days, the BAS will dis-enroll the provider and notify the supports coordinator that participants will need to identify a new provider. The supports coordinator will notify the participant that a new provider is~~	with the ID/A waivers.

	necessary. The BAS will send a notice of action to the provider to let the provider know that it can appeal the disenrollment decision to the DHS Bureau of Hearings and Appeals.	~~necessary. The BAS will send a notice of action to the provider to let the provider know that it can appeal the disenrollment decision to the DHS Bureau of Hearings and Appeals.~~ **Provider billings are verified through PROMISe. PROMISe includes edits to determine if the participant is eligible for Medicaid payment on the date of service and ensure that the service was part of the participant's service plan. The service is approved for payment by PROMISe only if the service is authorized and there are sufficient units available on the participant's service plan. Validation that the service has been provided occurs through the audit process at the end of the year.**	
I-3-g.ii	(Language purposely omitted. Please see approved Adult Autism Waiver for full language.) **Organized Healthcare Delivery System.** (a) Supports Coordination agencies can apply to become OHCDS entities for the Adult Autism Waiver services of Community Transition Services, Assistive Technology, Home Modifications**,** and/or Vehicle Modifications. Supports Coordination agencies qualify for OHCDS designation because they provide Supports Coordination as a direct service. Specialized Skill Development agencies can apply to become OHCDS entities for the Adult Autism Waiver service of Assistive Technology, and/or Vehicle Modifications. Specialized Skill Development agencies qualify for OHCDS designation because they provide Specialized Skill Development as a direct service. To assure that OHCDS subcontractors possess the required qualifications, when monitoring OHCDS, BAS reviews documentation that subcontractors possess the required qualifications. When monitoring OHCDS, BAS will review documentation of the contracting mechanism between the OHCDS and the provider. OHCDS is only allowed in this waiver for services for which providers are paid based on invoice costs—Home Modifications, Assistive Technology, Community Transition Services, and Vehicle Modifications. The cost of the service will vary based on the specific support a	Organized Healthcare Delivery System. (a) Supports Coordination ~~agencies~~ **organizations** can apply to become OHCDS entities for the Adult Autism Waiver services of Community Transition Services, Assistive Technology, Home Modifications**, Transportation** and/or Vehicle Modifications. Supports Coordination ~~agencies~~ **organizations** qualify for OHCDS designation because they provide Supports Coordination as a direct service. Specialized Skill Development agencies can apply to become OHCDS entities for the Adult Autism Waiver service**s** of Assistive Technology, **Transportation** and/or Vehicle Modifications. Specialized Skill Development agencies qualify for OHCDS designation because they provide Specialized Skill Development as a direct service. **Supported Employment agencies can apply to become OHCDS entities for the Adult Autism Waiver service of Transportation. Supported Employment agencies qualify for OHCDS designation because they provide Supported Employment as a direct service.** To assure that OHCDS subcontractors possess the required qualifications, when monitoring OHCDS, ~~BAS~~ **ODP** reviews documentation that subcontractors possess the required qualifications. When monitoring OHCDS, ~~BAS~~ **ODP** will review documentation of the contracting mechanism between the OHCDS and the provider. OHCDS is ~~only~~ allowed in this waiver for services for which providers are paid based on invoice costs—Home Modifications, Assistive Technology, Community Transition Services, **Transportation (Public), Transportation-Trip** and Vehicle Modifications. The cost of the service will vary based on the specific support a	ODP is adding Transportation to the services that can be provided through an OHCDS and modifying the types of service providers that can enroll as an OHCDS.

	person needs – different providers will have different rates because of the different supports provided. (b) Home Modifications, Community Transition Services, Assistive Technology, and Vehicle Modifications providers have the option to directly enroll as an Adult Autism Waiver provider should they not desire to work through an OHCDS. There is no limitation or restriction on vendors who wish to both directly enroll as providers as well as provide that service through an OHCDS. Any willing and qualified provider may enroll directly. OHCDS are not limited when contracting with vendors as long as they are qualified. (c) Participants in the AAW receive a complete list of providers of all waiver services at the time of enrollment, during the annual plan review, and at any other time by request. The list of providers of Community Transition Services, Assistive Technology, Home Modifications, and Vehicle Modification Services includes both OHCDS and providers directly enrolled to provide those services. Participants may exercise the right of choice from among all those providers enrolled for the service. When a Supports Coordination agency acts as an OHCDS, there is no incentive for the agency to refer a person to itself as an OHCDS. In the AAW, an OHCDS may not bill an administrative fee for acting as an OHCDS. The state pays the same amount—the provider's invoice cost—whether the person's chosen provider is directly enrolled or working through an OHCDS. (d) Agencies or individuals who provide Community Transition Services, Assistive Technology, Home and Vehicle Modifications must meet all Adult Autism Waiver requirements. The Supports Coordinator must document the successful delivery or completion of the services once completed. (e) & (f) BAS reviews all ISPs and scrutinizes Community Transition Services, Assistive Technology, Home Modifications, and Vehicle Modifications (and all services) to ensure they are necessary, appropriate, and that expenditures are	person needs – different providers will have different rates because of the different supports provided. **The invoices for Transportation-Trip will be based on the rate schedule as described in I-2-a and not individual provider rates.** (b) Home Modifications, Community Transition Services, Assistive Technology, **Transportation** and Vehicle Modifications providers have the option to directly enroll as an Adult Autism Waiver provider should they not desire to work through an OHCDS. There is no limitation or restriction on vendors **or providers** who wish to both directly enroll as providers as well as provide that service through an OHCDS. Any willing and qualified provider may enroll directly. OHCDS are not limited when contracting with vendors as long as they are qualified. (c) Participants in the AAW receive a complete list of providers of all waiver services at the time of enrollment, during the annual plan review, and at any other time by request. The list of providers of Community Transition Services, Assistive Technology, Home Modifications, **Transportation** and Vehicle Modification Services includes both OHCDS and providers directly enrolled to provide those services. Participants may exercise the right of choice from among all those providers enrolled for the service. ~~When a Supports Coordination agency acts as an OHCDS, there is no incentive for the agency to refer a person to itself as an OHCDS. In the AAW, an OHCDS may not bill an administrative fee for acting as an OHCDS. The state pays the same amount—the provider's invoice cost—whether the person's chosen provider is directly enrolled or working through an OHCDS.~~ (d) Agencies or individuals who provide Community Transition Services, Assistive Technology, Home **Modifications, Transportation** and Vehicle Modifications must meet all Adult Autism Waiver requirements. The Supports Coordinator must document the successful delivery or completion of the **Community Transition, Assistive Technology, Home Modifications, Transportation, and Vehicle Modifications** services once completed.	

	within the monetary limits for the service. Community Transition Services, Assistive Technology, Home Modifications, and Vehicle Modifications are subject to the same financial accountability oversight as other Adult Autism Waiver services. For a sample of Adult Autism Waiver participants, BAS reviews the Supports Coordination agency records and interviews with participants, family members, and provider staff to verify that services were furnished as billed. The sample is sufficient to obtain a 90% confidence level with a 10% margin of error. BAS will also ensure the arrangements between the OHCDS entity and the agency or individual providing the service meet OHCDS requirements. These arrangements may not be formal contracts as these services generally represent short term or single purchase transactions. The OHCDS does not perform administrative activities. The OHCDS-designated provider is the "provider of record" of the service. BAS holds the OHCDS accountable for the goods or services just as if they were the vendor. However, unlike other waiver services, the OHCDS may contract with a vendor to provide the goods or services as described in the service definitions in the AAW. The OHCDS is responsible for: • Identifying the vendor; • Specifying the terms of the service (what exactly the vendor will do or provide); • Accepting or negotiating the terms including the cost of the goods or services; • Ensuring that the vendor meets provider requirements specified in the AAW, such as licensing; • Ensuring that necessary permits are secured, and that the work meets standards of manufacture, installation, etc. • Determining that the contracted goods or services are satisfactorily completed and should be paid; • Receiving the invoice (including any receipts) from the vendor and paying the vendor directly. • Billing the AAW through PROMISe for the exact amount of the invoice from the vendor; • Retaining the invoice in its records.	(e) & (f) ~~BAS~~ **ODP** reviews all ISPs and scrutinizes Community Transition Services, Assistive Technology, Home Modifications, **Transportation** and Vehicle Modifications (and all services) to ensure they are necessary, appropriate, and that expenditures are within the monetary limits for the service. Community Transition Services, Assistive Technology, Home Modifications, **Transportation** and Vehicle Modifications are subject to the same financial accountability oversight as other Adult Autism Waiver services. For a sample of Adult Autism Waiver participants, ~~BAS~~ **ODP** reviews the Supports Coordination ~~agency~~ **organization** records and interviews with participants, family members, and provider staff to verify that services were furnished as billed. The sample is sufficient to obtain a 90% confidence level with a 10% margin of error. ~~BAS~~ **ODP** will also ensure the arrangements between the OHCDS entity and the agency or individual providing the service meet OHCDS requirements. **For Community Transition, Assistive Technology, Home Modifications, and Vehicle Modifications services, t**~~T~~hese arrangements may not be formal contracts as these services generally represent short term or single purchase transactions. ~~The OHCDS does not perform administrative activities.~~ The OHCDS-designated provider is the "provider of record" of the service. ~~BAS~~ **ODP** holds the OHCDS accountable for the goods or services just as if they were the vendor. However, unlike other waiver services, the OHCDS may contract with a vendor to provide the goods or services as described in the service definitions in the AAW. The OHCDS is responsible for: • Identifying the vendor; • Specifying the terms of the service (what exactly the vendor will do or provide); • Accepting or negotiating the terms including the cost of the goods or services; • Ensuring that the vendor meets provider requirements specified in the AAW, such as licensing; • Ensuring that necessary permits are secured, and that the work meets standards of manufacture, installation, etc.	

	As part of its annual monitoring activities, BAS verifies that the OHCDS met the above criteria if a participant in the monitoring sample received services using an OHCDS. If an OHCDS is used, once the service has been rendered, the vendor with whom the OHCDS has contracted submits a bill or invoice to the OHCDS. The OHCDS bills PROMISe for the exact amount of the bill or invoice using the procedure code for the service and using the appropriate provider type and specialty codes for the service. PROMISe verifies that the OHCDS agency is enrolled to provide that service in the AAW and that the participant has that service authorized on their ISP. The OHCDS must retain all invoices related to the cost on file and available for review by BAS. There is no additional cost to the state if a directly enrolled provider also provides services under contract with an OHCDS. The state pays the same amount—the provider's invoice cost—whether the person's chosen provider is directly enrolled or working through an OHCDS. Methods for Direct Provider Enrollment when a Provider does not Voluntarily Agree to Contract with a Designated OHCDS: Agencies wishing to provide Assistive Technology, Vehicle Modification, Home Modification, or Community Transition Services directly may enroll as AAW providers by following the same process as providers of other services in the AAW. Interested providers must first enroll with Pennsylvania's Office of Medical Assistance Programs. The provider then submits an application to provide services for the Adult Autism Waiver that is reviewed to ensure the provider meets the qualifications for the service(s) specified by the provider. If the provider meets the qualifications, the Medical Assistance supplemental agreement specific to the AAW is executed.	• Determining that the contracted goods or services are satisfactorily completed and should be paid; • Receiving the invoice (including any receipts) from the vendor and paying the vendor directly. • Billing the AAW through PROMISe for the exact amount of the invoice from the vendor; • Retaining the invoice in its records. As part of its annual monitoring activities, ~~BAS~~ **ODP** verifies that the OHCDS met the above criteria if a participant in the monitoring sample received services using an OHCDS. If an OHCDS is used, once the service has been rendered, the vendor with whom the OHCDS has contracted submits a bill or invoice to the OHCDS. The OHCDS bills PROMISe for the exact amount of the bill or invoice using the procedure code for the service and using the appropriate provider type and specialty codes for the service. PROMISe verifies that the OHCDS agency is enrolled to provide that service in the AAW and that the participant has that service authorized on their ISP. The OHCDS must retain all invoices related to the cost on file and available for review by ~~BAS~~ **ODP**. ~~There is no additional cost to the state if a directly enrolled provider also provides services under contract with an OHCDS. The state pays the same amount—the provider's invoice cost—whether the person's chosen provider is directly enrolled or working through an OHCDS.~~ Methods for Direct Provider Enrollment when a Provider does not Voluntarily Agree to Contract with a Designated OHCDS: Agencies wishing to provide Assistive Technology, Vehicle Modification, Home Modification, **Transportation** or Community Transition Services directly may enroll as AAW providers by following the same process as providers of other services in the AAW. Interested providers must first enroll with Pennsylvania's Office of Medical Assistance Programs. The provider then submits an application to provide services for the Adult Autism Waiver that is reviewed to ensure the provider meets the qualifications for the service(s) specified by the provider. If the provider meets the qualifications, the ~~Medical Assistance~~	

		~~supplemental agreement specific to the AAW~~ **ODP Waiver Provider Agreement** is executed.	
Appendix I-Quality Improvement: Financial Accountability			
I-a.i.a	**Performance Measure FA1: Number and percent of claims supported by documentation that services were delivered. Numerator = Number of claims supported by documentation that services were delivered. Denominator = Number of claims reviewed.** **Data Source** (Select one): **Other** If 'Other' is selected, specify: **Provider monitoring, Encounter forms, Provider Reimbursement Operations and Management System (PROMISe)** **Sampling Approach** *(check each that applies)*: **X Less than 100% Review** **X Representative Sample** Confidence Interval = 95% +/- 5%	Performance Measure FA1: Number and percent of claims supported by documentation that services were delivered. Numerator = Number of claims supported by documentation that services were delivered. Denominator = Number of claims reviewed. Data Source (Select one): Other If 'Other' is selected, specify: ~~Provider monitoring, Encounter forms,~~ **Participant record review and** Provider Reimbursement Operations and Management System (PROMISe) Sampling Approach *(check each that applies)*: X Less than 100% Review X Representative Sample Confidence Interval = ~~95% +/- 5%~~ **+/-5 Confidence level: 95%**	The language is updated to align with the ID/A waivers to include participant record review.
I-a.ii	If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The audits described in Appendix I-1 and the claims validation described in Appendix I-2-d help ensure payments are made only to qualified providers for services provided to waiver participants and authorized in the ISP. Ongoing billing validation is done first through PROMISe, Pennsylvania's Medicaid Management Information System (MMIS). PROMISe verifies participant information in the Client Information System (CIS), such as the participants Master Client Index (MCI) number, name, the participants eligibility status, and effective eligibility dates. PROMISe also verifies that the provider(s) and service(s) on the claim are enrolled providers of the services and the services are in the Adult Autism Waiver.	If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. ~~The audits described in Appendix I-1 and the claims validation described in Appendix I-2-d help ensure payments are made only to qualified providers for services provided to waiver participants and authorized in the ISP.~~ ~~Ongoing billing validation is done first through PROMISe, Pennsylvania's Medicaid Management Information System (MMIS). PROMISe verifies participant information in the Client Information System (CIS), such as the participants Master Client Index (MCI) number, name, the participants eligibility status, and effective eligibility dates. PROMISe also verifies that the provider(s) and service(s) on the claim are enrolled providers of the services and the services are in the Adult Autism Waiver.~~	ODP is aligning discovery with the ID/A waivers.

	After validation of the above listed items occurs, the claim information is sent to HCSIS to be verified against the participants ISP. If any of the information on the PROMISe claim is in conflict with the ISP, HCSIS sends an error code to PROMISe. PROMISe then suspends or rejects the claim. This system edit provides an upfront monitoring of eligibility status and authorized services as per the approved ISP. PROMISe then notifies providers of rejected claims; each denied claim has one or more denial codes associated with it that show the reasons for rejections. Providers can work through the denied claims to correct the error(s) and resubmit them. BAS further assures the state's accountability by reviewing all claims rejected by PROMISe on a quarterly basis. BAS monitors providers claims rejection status and provides necessary training and direction to limit such errors/rejections. To ensure services were provided as billed, during the annual monitoring cycle, BAS will review a representative sample of all claims billed and compare them to the provider's documentation which includes service notes, encounter forms and time sheets. During the monitoring, Program Monitors review provider claims for each participant in the monitoring sample for a period of three to six months. For the Supports Coordination service, BAS reviews a sample of service notes in HCSIS to assess whether billing reflects the amount of Supports Coordination activity recorded in the notes. If an irregularity is discovered, BAS will work with the provider to determine whether remediation is required. If a concerning issue is found, BAS will address the issue directly with the provider to come to a resolution or to offer training as needed. In addition, this review allows BAS to discover any potential systemic issues that may need to be addressed. Finally, BAS will monitor annually to ensure that the proper rates for BAS services are loaded into PROMISe for each service and unit of service. BAS also interviews participants during annual monitoring to assess whether participants reporting of service delivery is consistent with claims data.	~~After validation of the above listed items occurs, the claim information is sent to HCSIS to be verified against the participants ISP. If any of the information on the PROMISe claim is in conflict with the ISP, HCSIS sends an error code to PROMISe. PROMISe then suspends or rejects the claim. This system edit provides an upfront monitoring of eligibility status and authorized services as per the approved ISP. PROMISe then notifies providers of rejected claims; each denied claim has one or more denial codes associated with it that show the reasons for rejections. Providers can work through the denied claims to correct the error(s) and resubmit them.~~ ~~BAS further assures the state's accountability by reviewing all claims rejected by PROMISe on a quarterly basis. BAS monitors providers claims rejection status and provides necessary training and direction to limit such errors/rejections.~~ ~~To ensure services were provided as billed, during the annual monitoring cycle, BAS will review a representative sample of all claims billed and compare them to the provider's documentation which includes service notes, encounter forms and time sheets. During the monitoring, Program Monitors review provider claims for each participant in the monitoring sample for a period of three to six months. For the Supports Coordination service, BAS reviews a sample of service notes in HCSIS to assess whether billing reflects the amount of Supports Coordination activity recorded in the notes. If an irregularity is discovered, BAS will work with the provider to determine whether remediation is required.~~ ~~If a concerning issue is found, BAS will address the issue directly with the provider to come to a resolution or to offer training as needed. In addition, this review allows BAS to discover any potential systemic issues that may need to be addressed. Finally, BAS will monitor annually to ensure that the proper rates for BAS services are loaded into PROMISe for each service and unit of service.~~ ~~BAS also interviews participants during annual monitoring to assess whether participants reporting of service delivery is consistent with claims data.~~	

	Findings from the annual monitoring activities are aggregated to enable data analysis, e.g., compliance by region, by provider, or by service to identify trends in compliance. Another financial accountability check occurs at the time of review of each participant's annual level-of-care (LOC) documentation. If that documentation has lapsed, BAS instructs the participant's providers to suspend service delivery until the LOC documentation has been submitted. Once the documentation is reviewed and accepted, services are resumed for the participant. No capitation payments are paid under this waiver.	~~Findings from the annual monitoring activities are aggregated to enable data analysis, e.g., compliance by region, by provider, or by service to identify trends in compliance.~~ ~~Another financial accountability check occurs at the time of review of each participant's annual level-of-care (LOC) documentation. If that documentation has lapsed, BAS instructs the participant's providers to suspend service delivery until the LOC documentation has been submitted. Once the documentation is reviewed and accepted, services are resumed for the participant. No capitation payments are paid under this waiver.~~ **FA1 -ODP reviews a representative, random sample of claims annually to determine if they are supported by adequate provider documentation to substantiate that services were delivered.** **FA2 -The reimbursement logic built into Pennsylvania's Medicaid Management Information System (MMIS) ensures that waiver participants were eligible for services on the date the service was provided, and that services paid are authorized in the participant's approved service plan. A problem may be identified by a provider or providers, contractors, ODP staff, or Office of Medical Assistance Programs (OMAP). The ODP Claims Resolution Section monitors claims activity on a monthly basis to identify potential issues with the eligibility information, or services paid inconsistent with the services authorized in the service plan.** **FA3 -The reimbursement logic built into Pennsylvania's MMIS ensures that providers are not paid more than the rate that is stored in the system. A problem may be identified by a provider or providers, contractors, ODP staff, or OMAP. The ODP Claims Resolution Section monitors claims activity on a monthly basis to identify potential issues with the reimbursement rate.**	
I-b.i-ii	**Methods for Remediation/Fixing Individual Problems** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.	Methods for Remediation/Fixing Individual Problems Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.	ODP is aligning remediation with the ID/A waivers.

	On an ongoing basis, if a Supports Coordinator suspects that a provider is billing inappropriately, the Supports Coordinator will inform BAS staff by phone or e-mail of the situation. BAS staff may also suspect inappropriate billing and pursue that concern at the Regional Office level. For example, BAS may initiate an internal review of the provider's billing history through HCSIS reports and may expand that investigation. An expanded investigation could include onsite review of services rendered reports, time sheets, and claims to determine if inaccurate or inappropriate billings were submitted. If the suspicion is substantiated, BAS staff will require the provider agency to do an analysis of individual staff time sheets and/or other documentation and may request that the provider submit a summary report of findings and resolution to the BAS. During the annual monitoring activities described above, when a provider's claim(s) cannot be validated by the Program Monitor, the provider is instructed to remediate the finding appropriately, e.g., paid funds will be recouped. If a pattern of inaccurate provider billing is discovered during annual monitoring, this would be documented on the provider's monitoring findings and BAS requests a Plan of Correction to be developed. As deemed appropriate, a meeting would be held with BAS and the provider agency to correct the issue moving forward. In some cases, the provider could face sanctions or be terminated as an AAW service provider. Depending upon the findings of ad hoc and/or annual monitoring reviews, the following remediation strategies could be approved and carried out: o A time-limited monitoring by a provider supervisor of weekly time sheets submitted by the provider's staff; o Suspension of enrollment of new services or service locations for the provider; o Sanctions or termination of the provider's contract(s); o Recouping fund paid to the provider inappropriately; o Training of provider staff in documentation of services rendered and ongoing monitoring of that documentation; In any of the above situations, if the findings result in suspected fraud or abuse, BAS will report the provider staff or individual staff person to the DHS,	~~On an ongoing basis, if a Supports Coordinator suspects that a provider is billing inappropriately, the Supports Coordinator will inform BAS staff by phone or e-mail of the situation. BAS staff may also suspect inappropriate billing and pursue that concern at the Regional Office level.~~ ~~For example, BAS may initiate an internal review of the provider's billing history through HCSIS reports and may expand that investigation. An expanded investigation could include onsite review of services rendered reports, time sheets, and claims to determine if inaccurate or inappropriate billings were submitted. If the suspicion is substantiated, BAS staff will require the provider agency to do an analysis of individual staff time sheets and/or other documentation and may request that the provider submit a summary report of findings and resolution to the BAS.~~ ~~During the annual monitoring activities described above, when a provider's claim(s) cannot be validated by the Program Monitor, the provider is instructed to remediate the finding appropriately, e.g., paid funds will be recouped. If a pattern of inaccurate provider billing is discovered during annual monitoring, this would be documented on the provider's monitoring findings and BAS requests a Plan of Correction to be developed. As deemed appropriate, a meeting would be held with BAS and the provider agency to correct the issue moving forward. In some cases, the provider could face sanctions or be terminated as an AAW service provider.~~ ~~Depending upon the findings of ad hoc and/or annual monitoring reviews, the following remediation strategies could be approved and carried out:~~ ~~o A time-limited monitoring by a provider supervisor of weekly time sheets submitted by the provider's staff;~~ ~~o Suspension of enrollment of new services or service locations for the provider; o Sanctions or termination of the provider's contract(s);~~ ~~o Recouping fund paid to the provider inappropriately;~~ ~~o Training of provider staff in documentation of services rendered and ongoing monitoring of that~~ ~~documentation;~~ ~~In any of the above situations, if the findings result in suspected fraud or abuse, BAS will report the provider staff or individual staff person to the DHS,~~	

	Office of Administration for appropriate investigation and legal action as necessary. Regarding assuring that rates are consistent with the approved methodology, the reimbursement logic built into PROMISe ensures that providers are not paid more than the rate that is stored in the system; that waiver participants are eligible for services on the date the service was provided; and that services paid are authorized in the waiver participant's approved ISP. If there is a problem, it can be identified by the provider (s), contractors, BAS staff, or OMAP. The ODP Claims Resolution Section has the ability to conduct research to identify if the reimbursement or eligibility information was incorrect or whether 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 would be corrected and the universe of paid claims that was processed using the incorrect information would be identified and adjusted. 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. **ii. Remediation Data Aggregation** **Frequency of data aggregation and analysis** *(check each that applies):* **Quarterly**	~~Office of Administration for appropriate investigation and legal action as necessary.~~ ~~Regarding assuring that rates are consistent with the approved methodology, the reimbursement logic built into PROMISe ensures that providers are not paid more than the rate that is stored in the system; that waiver participants are eligible for services on the date the service was provided; and that services paid are authorized in the waiver participant's approved ISP. If there is a problem, it can be identified by the provider (s), contractors, BAS staff, or OMAP.~~ ~~The ODP Claims Resolution Section has the ability to conduct research to identify if the reimbursement or eligibility information was incorrect or whether 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 would be corrected and the universe of paid claims that was processed using the incorrect information would be identified and adjusted.~~ ~~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.~~ **FA1 -Number and percent of claims that are supported by documentation that services were delivered. If ODP finds inadequate provider documentation to support a claim, depending on the nature of the issue, additional records will be selected for review by ODP and the Department may initiate an expanded review or audit. If indicated, ODP will conduct further claims review and remediation activities as appropriate. The provider will be requested to submit a corrective action plan (CAP) that will specify the remediation action taken. Remediation is expected to occur within 30 days of the CAP approval date. Remediation may include locating documentation to support that services rendered are consistent with claim submission, training, voiding (and/or recovering) payments, and the initiation of provider sanctions, if the situation warrants. Department**	

		sanctions may range from restricting the provider from serving additional participants to the termination of the agency's waiver program participation. Department staff will ensure that payments are adjusted where necessary and determine if the extent of the problem warrants further action. **FA2 -Number and percent of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans. If a problem is identified, outreach is conducted with the provider and appropriate corrective action is conducted in a timely manner. Providers are expected to correct payments for inappropriate claims within 30 days of notification or discovery.** **Trends are monitored to identify systemic errors which are corrected in collaboration with the MMIS contractor if necessary and, with the contractor who supports HCSIS, if applicable. Remediation is expected within 30 days.** **Eligibility information entered into the system incorrectly is 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 Federal Medical Assistance Percentages (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.** **FA3 -Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. If a problem is identified, outreach is conducted with the provider and appropriate corrective action is conducted in a timely manner. Providers are expected to correct payments for inappropriate claims within 30 days of notification or discovery.** **Trends are monitored to identify systemic errors which are corrected in collaboration with the MMIS contractor if necessary and, with the contractor**	

		who supports HCSIS, if applicable. Remediation is expected within 30 days of notification or discovery. **Rates 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.** ii. Remediation Data Aggregation Frequency of data aggregation and analysis (check each that applies): ~~Quarterly~~ **X Annually**	