Pennsylvania's Home and Community-Based Services (HCBS) Settings CMS Final Rule Statewide Transition Plan

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Background

In January 2014, the Centers for Medicare & Medicaid Services (CMS) issued a new rule (CMS rule) that states must follow to review and evaluate settings in which home and community-based services (HCBS) are provided, which include residential and nonresidential settings. The CMS rule became effective on March 17, 2014 and requires states to demonstrate compliance. To show compliance, states must submit a statewide transition plan (STP) and waiver specific transition plans.

According to CMS, the rule was issued to ensure that individuals receiving long-term services and supports through HCBS programs under the 1915(c), 1915(i), and 1915(k) Medicaid authorities have full access to benefits of community living, the opportunity to receive services in the most integrated setting appropriate to enhance the quality of HCBS, and provide protections to participants. CMS' definition of HCBS settings has evolved over the past five years, based on experience throughout the country and extensive public feedback about the best way to differentiate between institutional and home and community-based settings.

CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of participants' experiences. The home and community-based setting provisions in this final rule established a more outcome-oriented definition of home and community-based settings, as opposed to one based solely on a setting's location, geography, or physical characteristics.

Pennsylvania submitted a STP to CMS on April 1, 2015, following input from a public comment process. The Department received a letter from CMS on September 16, 2015, outlining questions and suggested changes for STP. The Department released the revised STP for public comment on January 9, 2016 and submitted a revised STP to CMS in March 2016, along with a summary of comments received.

Summary of the Centers for Medicare & Medicaid Services Requirements

All Settings

The CMS rule contains the following requirements for all HCBS settings:

- Integrates in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community - to the same degree of access as individuals not receiving Medicaid HCBS.
- Allows the individual to select from setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- Facilitates individual choice regarding services and supports, and who provides them.

Provider-Owned or Controlled Residential Setting

In a provider-owned or controlled residential setting, in addition to the above qualities, the following additional conditions must be met:

- The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

- Each individual has privacy in his or her sleeping or living unit.
- Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed.
- Individuals sharing units have a choice of roommates in that setting.
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- Individuals are able to have visitors of their choosing at any time.
- The setting is physically-accessible to the individual.

Any modification of the above requirements must be supported by a specific assessed need and justified in the person-centered service plan.

CMS-Identified Unallowable Settings

Home and community-based settings do not include the following:

- Nursing facilities;
- Institutions for mental diseases;
- Intermediate care facility for individuals with intellectual disabilities;
- Hospitals; or
- Other locations that have qualities of an institutional setting, as determined by the Secretary of the United States Department of Health & Human Services.

CMS-Identified Presumed Unallowable Settings

Any setting located in a building that is also a publicly or privately operated facility providing inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary of the United States Department of Health & Human Services determines through heightened scrutiny, based on information presented by the state or other parties, the setting does not have the qualities of an institution and the setting does have the qualities of home and community-based settings.

Overview of Pennsylvania's 1915(a) Program and 1915(c) Waivers

The Pennsylvania Secretary of the Department of Human Services (Department) is the head of the single state Medicaid Agency and has ultimate authority over the operations of the 1915(a) program and all 1915(c) waiver programs. The Office of Child Development and Early Learning (OCDEL), the Office of Developmental Programs (ODP), and the Office of Long Term Living (OLTL) report to the Secretary and administer the 1915(c) waiver programs. The 1915(a) program is administered by ODP.

There is one 1915(a) program and nine 1915(c) waivers operating in Pennsylvania that are affected by the final rule:

- Adult Community Autism Program (ACAP)
- Infants, Toddlers, and Families Waiver (ITF)
- Adult Autism Waiver (AAW)
- Consolidated Waiver
- Person/Family-Directed Support (P/FDS) Waiver
- Aging Waiver
- Attendant Care Waiver
- COMMCARE Waiver
- Independence Waiver
- OBRA Waiver

Please note that Pennsylvania's AIDS Waiver was terminated on September 27, 2015, therefore it is not included in this transition plan.

OCDEL Waiver

Infants, Toddlers, and Families (ITF) Waiver - The ITF Waiver serves infants and toddlers, birth to age three who are experiencing developmental delay(s) as evidenced by a minimum of a 50 percent delay in one developmental area or a 33 percent delay in two developmental areas, who need early intervention services and are eligible for an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/IID) or an Intermediate Care Facility for Persons with other Related Conditions (ICF/ORC) level of care. Habilitation is the only service available under the ITF Waiver. Habilitation consists of the assistance and acquisition, retention or improvement of skills related to activities of daily living, such as feeding and dressing; communication with caregivers; orientation and mobility; and social development needed by the child. Habilitation is delivered by qualified providers pursuant to an individually written plan of care, in natural environments with the participation of the family or caregiver. The child's natural

environment is primarily the child's home, however, may also be in a community setting, such as a child care facility, park, or grocery store.

ODP Program and Waivers

Adult Community Autism Program (ACAP) – Serves individuals diagnosed with autism age 21 and over who are eligible for Medicaid; are certified as requiring services at the level of an ICF; meet certain functional eligibility; and live in one of the available service areas at the time of enrollment. The following services are available through ACAP:

- Podiatrist services
- Nurse practitioner services
- Certified registered nurse services
- Intermediate care facility (ICF)
- Non-emergency medical transportation to services covered under the Medical Assistance program
- Nursing facility services
- Optometrists' services
- Chiropractors' services
- Audiologist services
- Dentist services
- Health promotion and disease prevention services
- Medical supplies and durable medical equipment
- Outpatient psychiatric clinic services
- Respiratory Services
- Targeted case management
- Assistive technology
- Family counseling
- Homemaker/chore services
- Pre-vocational services
- Respite
- Supports coordination
- Prosthetic eyes and other eye appliances
- Hospice services
- Mental health crisis intervention services
- Behavioral support (similar to Behavioral Specialist Services in the Adult Autism Waiver
- Community transition services
- Crisis intervention services
- Adult day habilitation

- Environmental modification
- Habilitation
- Non-medical transportation
- Personal assistance services
- Residential support (similar to residential habilitation)
- Supported employment
- Visiting nurse
- Additional services determined necessary
- Physical, occupational, vision and mobility, and speech therapies (group and individual)

Adult Autism Waiver (AAW) - Serves individuals diagnosed with autism age 21 and over who are financially eligible for Medicaid waiver services and are clinically eligible for; 1) ICF/ORC, or 2) ICF/IID. The following services are available through the AAW:

- Day Habilitation
- Residential Habilitation
- Respite
- Supported Employment
- Supports Coordination
- Therapies
- Assistive Technology
- Career Planning
- Community Transition Services
- Family Support
- Home Modifications
- Nutritional Consultation
- Specialized Skill Development
- Temporary Supplemental Services
- Transitional Work Services
- Vehicle Modifications

Consolidated Waiver - Serves individuals who: are age 3 and older, have a diagnosis of an intellectual disability, have been recommended for an ICF/ID level of care based on a medical evaluation, and are financially eligible for Medicaid waiver services. The following services are available through the Consolidated Waiver:

- Education Support
- Home and Community Habilitation
- Homemaker/Chore

- Licensed Day Habilitation
- Prevocational Services
- Residential Habilitation (Consolidated Waiver Only)
- Respite
- Supported Employment
- Supports Coordination
- Nursing
- Therapy Services
- Supports Broker Services
- Assistive Technology
- Behavioral Support
- Companion
- Home Accessibility Adaptations
- Specialized Supplies
- Transitional Work Services
- Transportation
- Vehicle Accessibility Adaptations

Person/Family-Directed Support (P/FDS) Waiver - Serves individuals who: are age 3 and older, have a diagnosis of an intellectual disability, have been recommended for an ICF/ID level of care based on a medical evaluation, and are financially eligible for Medicaid waiver services. The following services are available through the P/FDS Waiver:

- Education Support
- Home and Community Habilitation
- Homemaker/Chore
- Licensed Day Habilitation
- Prevocational Services
- Respite
- Supported Employment
- Supports Coordination
- Nursing
- Therapy Services
- Supports Broker Services
- Assistive Technology
- Behavioral Support
- Companion
- Home Accessibility Adaptations
- Specialized Supplies
- Transitional Work Services
- Transportation
- Vehicle Accessibility Adaptations

OLTL Waivers

Aging Waiver - Serves individuals age 60 and over who are nursing facility clinically eligible and financially eligible for Medicaid waiver services. The following services are available through the Aging Waiver:

- Home Adaptations
- Specialized Medical Equipment and Supplies
- Assistive Technology
- Adult Daily Living Services
- Community Transition Services
- Home Delivered Meals
- Home Health Services
- Non-Medical Transportation Services
- Participant-Directed Community Supports
- Participant-Directed Goods and Services
- Personal Assistance Services
- Personal Emergency Response System (PERS)
- Respite
- Service Coordination
- TeleCare
- Therapeutic and Counseling Services

Attendant Care Waiver - Serves individuals ages 18 to 59 with physical disabilities who are mentally alert, nursing facility clinically eligible, and financially eligible for Medicaid waiver services. The following services are available through the Attendant Care Waiver:

- Community Transition Services
- Participant-Directed Community Supports
- Participant-Directed Goods and Services
- Personal Assistance Services
- Personal Emergency Response System (PERS)
- Service Coordination

COMMCARE Waiver - Serves individuals over the age of 21 who are nursing facility clinically eligible, have a traumatic brain injury, and are financially eligible for Medicaid waiver services. The following services are available through the COMMCARE Waiver:

- Adult Daily Living
- Therapeutic and Counseling Services
- Personal Emergency Response System (PERS)

- Service Coordination
- Home Adaptations
- Specialized Medical Equipment and Supplies
- Assistive Technology
- Vehicle Modifications
- Supported Employment
- Respite
- Community Transition Services
- Non-Medical Transportation
- Home Health
- Residential Habilitation
- Structured Day Habilitation
- Personal Assistance Services
- Prevocational Services
- Community Integration
- Financial Management Services

Independence Waiver - Serves individuals ages 18 to 60 with physical disabilities who are nursing facility clinically eligible and financially eligible for Medicaid waiver services. The following services are available through the Independence Waiver:

- Adult Daily Living
- Therapeutic and Counseling Services
- Personal Emergency Response System (PERS)
- Service Coordination
- Home Adaptations
- Specialized Medical Equipment and Supplies
- Assistive Technology
- Vehicle Modifications
- Supported Employment
- Respite
- Community Transition Services
- Non-Medical Transportation
- Home Health
- Personal Assistance Services
- Community Integration
- Financial Management Services

OBRA Waiver - Serves individuals ages 18 to 59 with a developmental disability who meets the level of care for ICF/ORC, and is financially eligible for Medicaid waiver services. The following services are available through the OBRA Waiver:

- Adult Daily Living
- Personal Assistance Services
- Prevocational Services
- Residential Habilitation Services
- Respite
- Service Coordination
- Structured Day Habilitation Services
- Supported Employment
- Home Health
- Financial Management Services
- Home Adaptations
- Specialized Medical Equipment and Supplies
- Assistive Technology
- Vehicle Modifications
- Community Integration
- Community Transition Services
- Non-Medical Transportation
- Personal Emergency Response System
- Therapeutic and Counseling Services

Overview of the Statewide Transition Plan

To develop Pennsylvania's plan to comply with the CMS rule, the Department created a workgroup consisting of staff from the three program offices and the policy, communications, and legal offices. The task was to develop Pennsylvania's STP that provides consistent guidance to consumers and providers while acknowledging the unique needs of all populations and the variations in how services are delivered.

Differences in each program offices' populations, resources, structure, and scope of services provided requires variances in each office's approach to certain sections of the STP. These differences are noted and outline the requirements of the new CMS rule along with the actions Pennsylvania will take to establish compliance. More detail on each step of the process is available in the included waiver specific transition plans, as steps vary due to the unique structure of each waiver. Additionally, ODP and OLTL are currently in the process of making sweeping changes to the way they deliver services, which must occur in conjunction with the STP.

ODP developed a stakeholder group called the Information Sharing and Advisory Committee (ISAC). The purpose of this committee is to continuously engage with the stakeholder community on regulations and department updates, sustaining an inclusive, person-centered focus that is transparent to participants and the community while providing accountability to all parties involved. Through the ISAC, ODP will develop new regulations that not only incorporate the changes needed to comply with the CMS rule, but will increase access to high-quality services and improve outcomes for consumers. Through this process, the CMS rule will not be seen as a separate area of compliance, but will be ingrained in the practice of HCBS providers.

OLTL is currently developing and procuring managed long-term services and supports for Medicaid eligible individuals with physical disabilities, older Pennsylvanians, and individuals dually eligible for Medicaid and Medicare. This new program, called Community HealthChoices (CHC), will reform the way in which individuals will access long-term services and supports and will increase coordination with physical health and behavioral health services. Compliance with the CMS rule on home and community-based services will be a requirement for providers to participate in CHC.

Outreach & Engagement

To engage public input on the STP and waiver specific transition plans, Pennsylvania held public forums, reached out to providers, issued public notices for comment conducted public webinars, formed stakeholder focus groups, regularly published policy bulletins, and transmitted informational surveys.

Prior to Pennsylvania's STP submission to the CMS on April 1, 2015, the Department sought public input on two separate occasions as described below:

1. August 16, 2014 the STP was published for public comment.
    - Official notification of the STP and request for public comment on the STP was issued in the Pennsylvania Bulletin. The Department made public comment opportunities available and received comments via mailed submissions, email, and by direct contact with Department staff. Written feedback was received from multiple advocates/advocacy organizations and other stakeholders. Persons with disabilities who required an auxiliary aid or service were offered the Pennsylvania AT&T Relay Service.
        - The Pennsylvania Bulletin is available online or through subscription. The published bulletin indicated how to obtain hard copies of the STP. The public notice can be found at: http://www.pabulletin.com/secure/data/vol44/44-33/1755.html.
        - Notice of availability of hard copies was also shared via ListServs to providers, advocacy organizations, and other interested parties.
        - Notification was also done through stakeholder outreach via support groups and the Autism Services Education Resources and Training (ASERT) Resource Center, including flyers distributed at events directing readers on how to access copies of the STP and encouraging submission of comments.
    - A series of public forums, held throughout the state, allowed for a more personal approach to gathering feedback on the STP.
    - The STP was presented during the Medical Assistance Advisory Committee (MAAC). This committee includes participant representation as well as provider and advocacy representation.
    - The STP was also presented at the Long-Term Care Subcommittee of the MAAC. This committee also includes participant representation as well as provider and advocacy representation. All members of this committee are responsible for reaching out to their constituencies to make them aware of the information that is presented at the meetings as well as soliciting their input when asked to review and provide feedback on documents.

2. The STP was revised and republished for public comment on February 21, 2015.
   - Official notification of the revised STP and request for public comment was issued in the Pennsylvania Bulletin. The Department made public comment opportunities available and received comments via mailed submissions, email, and by direct contact with Department staff. Written feedback was received from multiple advocates/advocacy organizations and other stakeholders. Persons with disabilities who required an auxiliary aid or service were offered the Pennsylvania AT&T Relay Service.
     - The Pennsylvania Bulletin is available online or through subscription. The published bulletin indicated how to obtain hard copies of the STP. The public notice can be found at: http://www.pabulletin.com/secure/data/vol45/45-8/329.html.
     - Notice of availability of hard copies was also shared via ListServs to providers, advocacy organizations, and other interested parties.
     - Notification was also done through stakeholder outreach via support groups and the ASERT Resource Center, including flyers distributed at events directing readers on how to access copies of the STP and encouraging submission of comments.
   - The STP was presented during the MAAC.

   The STP was also presented at the Long-Term Care Subcommittee of the MAAC. All comments and suggestions received were carefully considered and incorporated as appropriate into this final submission of the STP on April 1, 2015. On September 16, 2015, the Department received a letter from CMS with questions and a request for a meeting to discuss. A copy of the letter can be found at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/pa/pa-cmia.pdf.

   The meeting with CMS was held on October 6, 2015 and the Department was given until March of 2016 to resubmit a revised STP.

3. The STP was revised and published for public comment on January 9, 2016.
   - Official notification of a revised STP and request for public comment was issued in the Pennsylvania Bulletin. The Department has made public comment opportunities available via mailed submissions, email, and by direct contact with Department staff. Persons with disabilities who required an auxiliary aid or service have been offered the Pennsylvania AT&T Relay Service.
     - The Pennsylvania Bulletin is available online or through subscription. The published bulletin indicated how to obtain hard copies of the STP. The public notice can be found at:

    http://www.pabulletin.com/secure/data/vol46/46-2/53.html.
    - Notice of availability of hard copies has also been shared via ListServs to providers, advocacy organizations, and other interested parties.
    - Notification has also been done through stakeholder outreach via support groups and the ASERT Resource Center, including flyers distributed at events directing readers on how to access copies of the STP and encouraging submission of comments.
- The Department presented the STP at the MAAC on January 21, 2016.
- The Department presented the STP at the Long-Term Care Subcommittee of the MAAC on February 9, 2016.
- The Department held two public webinars to present the STP on January 22, 2016 and February 1, 2016.

Individual Waiver Transition Plans

While coordinated outreach was conducted in the above activities, ODP and OLTL also conducted separate outreach to their respective providers and participants.

ODP held two webinars to receive comments on the waiver specific transition plans for the Consolidated, P/FDS, and Adult Autism waivers. These two webinars were held on January 14, 2015 and January 15, 2015. All ODP waiver specific transition plan documents can be accessed at:

http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeofdevelopmentalprograms/ODPHCBS/index.htm#.Vky933arSWg.

ODP convened a group of stakeholders to discuss the CMS rule on home and community-based settings and its implications on the services provided through the Consolidated Waiver, P/FDS Waiver, and AAW. The 42 stakeholders represented participants with an intellectual disability, individuals with autism, family members, advocates, county government, supports coordinators, direct care staff, provider agencies, educational institutions, and other state agencies. Participants came with different personal and professional experiences including pre-vocational providers, community integrated employment providers, residential habilitation providers, day habilitation providers, families whose children attend pre-vocational programs or day habilitation programs, and participants who are competitively employed.

While the three-day session did not end with a consensus, there did seem to be a general recognition that the status quo would not be acceptable and could not continue. Participants indicated there were a number of steps the state could take to move the system in the direction envisioned by CMS and that these steps should be carefully planned and implemented to minimize unintended consequences for the individuals we

serve, even if this takes ODP longer to achieve than March of 2019. Participants urged ODP to consider the full range of abilities and needs of individuals and to ensure a wide range of services are available that will provide opportunities for each individual to grow and achieve his or her goals.

ODP has also formed the ISAC. The purpose of this committee is to continuously engage with the stakeholder community on regulations and department updates, sustaining an inclusive, person-centered focus that is transparent to participants and the community while providing accountability to all parties involved.

OLTL held a stakeholder meeting on May 7, 2015 to discuss the CMS rule on home and community-based settings. There were 35 attendees representing various associations, participants, advocates, providers, and Department staff. OLTL staff presented an overview of the CMS rule and preliminary data results of a provider self-survey that was issued in April 2015. Stakeholder input was provided on what compliance would look like, how providers could become compliant, barriers to compliance and strategies for continued engagement and communication with stakeholders. Stakeholders overwhelmingly expressed that OLTL should be flexible in interpreting the rule (consumer advocates, however, disagreed). Overall, stakeholders felt that a "one size fits all" will not work, especially when evaluating providers. In addition, stakeholders believed that person-centered planning should hold the most weight and be considered as the lynchpin moving forward with an approach to implement the CMS rule. A summary report of the meeting can be found on the OLTL website at:

http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm

For both ODP and OLTL, information and updates were provided to the Long-Term Care Subcommittee on August 11, 2015 and October 13, 2015. For both offices' additionally, service and support coordinators and direct service providers were asked to share a fact sheet regarding the CMS rule with waiver participants. A copy of the fact sheet can be found in Appendix J.

In addition, in order to provide OLTL with ongoing advice, a subcommittee of the Department of Human Services' Medical Assistance Advisory Committee (MAAC) has been established. The purpose of the Managed Long-Term Services and Supports (MLTSS) Subcommittee will be to review materials and advise the MAAC and the Department on policy development, program administration, and new and innovative approaches to long-term services as the Commonwealth rolls out the new CHC delivery model. It will provide OLTL with advice on the design, implementation and ongoing operations, oversight, and quality management of the CHC program. Membership of the

committee includes consumers of long-term living services, providers of services, family caregivers, and advocates. The MLTSS Subcommittee meets monthly to discuss the proposed policies and changes. OLTL will be using this forum to communicate any updates or changes to the STP as well as the OLTL waiver specific transition plan updates. Lastly, OLTL conducts stakeholder webinars every third Thursday of the month. These webinars have been primarily focused on the implementation of CHC, however, moving forward; OLTL believes this is a great opportunity to provide education and information on the STP as well as the OLTL waiver specific transition plans to our stakeholders.

Assessment

Systemic Review of Regulations, Policies, and Service Definitions:

A state-level assessment of regulations, policy bulletins, and service definitions was conducted to determine alignment with the federal requirements. This state-level assessment was conducted jointly by the Department in collaboration with the Bureau of Human Services Licensing and the Department of Aging. All current regulations, bulletins, and waiver service definitions that pertain to services delivered through Pennsylvania's 1915 (c) waivers were reviewed in their entirety. While the assessment found no direct conflicts with the new federal requirements; regulations, bulletins and service definitions will be developed or revised to address areas where all documents reviewed were found to be silent in regard to the federal requirements and to provide objective and measurable standards.

Regulations: This thorough review found that there are no regulations in conflict with the CMS rule. While changes to the licensing regulations were not necessary, the Department has drafted changes to four codes of regulations that are applicable to four specific types of settings which incorporate components of the CMS rule into the code: 55 Pa. Code Chapters 2380 (relating to Adult Training Facilities); 2390 (relating to Vocational Facilities); 6400 (relating to Community Homes for Individuals with Mental Retardation); and 6500 (relating to Family Living Homes). In addition ODP has engaged stakeholders in drafting a new set of regulations (Ch. 6100) that will govern all ODP HCBS and incorporate the broader set of requirements in the CMS rule including practices governing person-centered planning, rights, and conflict-free case management.

Policy Bulletins: A thorough review found that there are no bulletins in conflict with the CMS rule. Bulletins generally interpret regulations and other requirements and will be amended following the adoption of new regulations and service definitions.

Service Definitions: A review of service definitions found that none were in conflict with the CMS rule. However, in order to establish clear and objective standards against which to measure and enforce compliance with the CMS rule across a vast array of services serving multiple individuals of all ages and with varying degrees of service needs, the Department must develop services definitions with provider qualifications, standards, performance measures with measurable compliance thresholds, and provider monitoring protocols that incorporate the CMS rule.

The five requirements in the HCBS final rule that require objective and measurable standards for enforcement are:

1) *Integrated in and supports full access of individuals to the greater community*

    - Provides opportunities to seek employment, work in competitive integrated settings, engage in community life, control personal resources, and
    - Ensures that individuals receive services in the community, to the same degree of access as individuals not receiving HCBS

2) *Selected by the individual from among setting options including non-disability specific settings and options for a private unit in a residential setting*

    - Person-centered service plans document the options based on the individual's needs, preferences, and for residential settings, resources available for room and board

3) *Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint*

4) *Optimizes individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact*

5) *Facilitates individual choice regarding services and supports, and who provides them*

Regulatory changes will be released for public comment prior to promulgation. Revised service definitions, standards and provider qualifications that will ensure all services provided through the 1915(c) waivers are compliant with the CMS rule will be subject to a public comment period. The detailed results of this assessment are included in Appendix I.

Any settings or residences where individuals live or receive services under the 1915(a) managed care Adult Community Autism Program that overlap with the settings where an individual would live or receive services in a 1915(c) program if they chose to opt out of the 1915(a) managed care program, are included in the STP and fully comply with the requirements of the federal HCBS settings rule.

The Department will presume that all waiver services provided in a private home meet the requirements of the CMS rule. Because the infants and toddlers served in the Infants, Toddler, and Families Waiver live and receive services primarily in their own private homes, or in a community setting that is typical for the child's age peers, where children without a disability are likely to attend, the state presumes that all services provided through the this waiver meet the requirements of home and community-based settings and are compliant with the CMS rule.

All other services through the Medicaid waivers may be operated under standards that do not currently meet the CMS rule. Assessment of these settings will be conducted following the adoption of final service definitions and standards. This process is described in more detail in the Provider Monitoring section of this plan.

As of July 2015, the following numbers of service locations were enrolled to provide waiver services. Please note that these numbers do not represent unique service locations within Pennsylvania as some locations may serve individuals from multiple waivers.

Providers:

OCDEL has 563 providers enrolled to provide early intervention services (ITF Waiver).

ODP has the following breakdown by waiver.

Residential service locations for the Consolidated Waiver:

21 service locations licensed under 55 Pa. Code Chapter 3800 pertaining to Child Residential and Day Treatment Facilities.

- 18 service locations licensed under 55 Pa. Code Chapter 5310 pertaining to Community Residential Rehabilitation Services for the Mentally Ill.
- 4036 service locations licensed under 55 Pa. Code Chapter 6400 pertaining to Community Homes for Individuals with an Intellectual Disability.
- 1093 service locations licensed under 55 Pa. Code Chapter 6500 pertaining to Family Living Homes.
- 539 unlicensed residential service locations where three or fewer people with an intellectual disability who are 18 years of age or older and who need a yearly average of 30 hours or less direct staff contact per week per home reside.

Other licensed service locations for the Consolidated and P/FDS Waivers:

- 335 service locations licensed under 55 Pa. Code Chapter 2380 pertaining to Adult Training Facilities. Licensed Day Habilitation is the waiver service provided at these locations.
- 135 service locations licensed under 55 Pa. Code Chapter 2390 pertaining to Vocational Facilities. Prevocational services are the waiver services provided at these locations.

The Adult Autism Waiver had the following residential service locations:

- 307 service locations licensed under 55 Pa. Code Chapter 6400 pertaining to Community Homes for Individuals with an Intellectual Disability.

- 116 service locations licensed under 55 Pa. Code Chapter 6500 pertaining to Family Living Homes.

The Adult Autism Waiver had the following service locations:

- 93 service locations licensed under 55 Pa. Code Chapter 2380 pertaining to Adult Training Facilities. Licensed Day Habilitation is the waiver service provided at these locations.

OLTL has the following breakdown of licensed settings by waiver.

The Aging Waiver has the following service locations:

- 49 service locations licensed under 6 Pa. Code 11 pertaining to older Adult Daily Living Services.
- 1 service location licensed under 6 Pa. Code 21 pertaining to Domiciliary Care Services for Older Adults.

The COMMCARE Waiver has the following service locations:

- 43 service locations licensed under 55 Pa. Code Chapter 2600-Personal Care Homes pertaining to Residential Habilitation Services.
- 24 service locations licensed under 6 Pa. Code 11 pertaining to Older Adult Daily Living Services.
- 12 service locations licensed under 55 Pa. Code Chapter 2390-Vocational Facilities pertaining to Prevocational Services.
- 1 service location licensed under 55 Pa. Code Chapter 2380-Adult Training Facilities pertaining to Adult Daily Living.

The Independence Waiver has the following service locations:

- 30 service locations licensed under 6 Pa. Code 11 pertaining to older Adult Daily Living Services.
- 1 service location licensed under 55 Pa. Code Chapter 2380-Adult Training Facilities pertaining to Adult Daily Living.

The OBRA Waiver has the following service locations:

- 28 service locations licensed under 6 Pa. Code 11 pertaining to Older Adult Daily Living Services.
- 29 service locations licensed under 55 Pa. Code Chapter 2600-Personal Care Homes pertaining to residential Habilitation Services.
- 14 service locations licensed under 55 Pa. Code Chapter 2390-Vocational Facilities pertaining to Prevocational Services.

- 2 service locations licensed under 55 Pa. Code Chapter 2380-Adult Training Facilities pertaining to Adult Daily Living.

Provider Survey Process

The Department surveyed all providers of waiver services administered by ODP and OLTL to learn how services are currently being provided. The survey was used as a tool to begin gathering information from HCBS providers to inform the assessment process. Providers were instructed to complete the survey for each enrolled site location in which services are provided. For instance, if a provider has a home office (no services provided) and four locations where services are provided, four surveys would be completed. If a provider is enrolled with both ODP and OLTL to provide services in shared settings, one survey could be used to provide information for both offices. The survey was open for the period of April 2, 2015 to April 30, 2015. Both an electronic and a paper version of the survey were made available. The Department received 5,324 valid survey responses. The Electronic Provider Self-Assessment tool may be found at: http://questionpro.com/t/ALHsBZSEE4.

ODP received 4,792 completed surveys providing services for one or more ODP waivers. As of July 2015, there were 806 ODP providers who operated at 7,742 service locations, meaning that 83 percent of all providers responded to the survey (62 percent of all provider-operated service locations responded). Online survey research response rates that exceed 30 percent of the total population are considered representative in accordance with standard research practices. A detailed survey analysis from ODP may be found at:
http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeofdevelopmentalprograms/ODPHCBS/index.htm.

OLTL received 775 completed surveys by 431 distinct providers. At the time the survey was distributed, 1,100 providers were enrolled to provide services for OLTL. The 431 respondents represent a 39 percent response rate of all enrolled OLTL HCBS providers. OLTL compiled and analyzed data from the provider self-surveys as to whether they conform to the CMS rule characteristics and their ability to comply in the future. A detailed survey analysis from OLTL may be found at:
http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeoflongtermliving/oltlwaiverinfo/index.htm

OLTL is conducting follow-up visits to settings in order to validate the survey results for OLTL's waivers and gather additional information to help inform policy development.

Based on the systemic review, the provider self-survey, and the on-site monitoring visits, OLTL will preliminarily identify the following for OLTL waiver providers:

(1) Settings which are fully compliant;
(2) Settings that are not fully compliant but will be able to come into compliance through the transition planning process;
(3) Setting that are presumed non-compliant but evidence may be presented for heightened scrutiny review; and
(4) Settings that do not comply.

Policy Development

Publication of Policy, Regulations, and Waiver Amendments/Renewals

OCDEL

It is the Department's position that all services provided through the Infants, Toddlers, and Families waiver meet the requirements of home and community-based settings and are compliant with the CMS rule. For this reason, no changes are needed to policies, regulations or waivers.

ODP

ODP is drafting 55 Pa. Code Chapter 6100 regulations with stakeholder input. These regulations will replace 55 Pa. Code Chapter 51 and govern HCBS provided through the AAW, Consolidated Waiver, and the P/FDS Waiver. At the same time, service definitions and provider qualification criteria will also be drafted for all three of the ODP waivers with stakeholder input during fiscal year 2015-2016. This will include a two tiered set of standards: One that must be met by current providers and a different set of standards for providers that are newly enrolling to provide services. Some examples of two tiered standards that ODP is exploring include: 1) Implementing different limits on the number of people who can receive services in residential settings as well as Adult Training Facilities and Vocational Facilities depending on when the provider enrolls; and 2) Implementing different requirements about where residential settings, Adult Training Facilities, and Vocational Facilities can be located depending on when the provider is enrolled. It is important to note that at the time this transition plan was written, exact changes have not been published for public comment and no final decisions have been made. The Department intends for the drafted regulations to go out for public comment in September 2016 and for proposed service definitions and provider qualification criteria to go out for public comment in October 2016. The Department intends for the service definitions and provider qualification criteria to be effective on July 1, 2017 and for the regulations to be issued in October 2017.

OLTL

As referenced earlier, The Pennsylvania Department of Human Services' Office of Long-Term Living (OLTL) is developing a new managed long-term service and supports program for older Pennsylvanians and adults with physical disabilities called Community HealthChoices (CHC). The vision for CHC is an integrated system of physical health and long-term Medicare and Medicaid services that supports older adults and adults

with physical disabilities to live safe and healthy lives with as much independence as possible, in the most integrated settings possible. The program will roll out in three phases over three years, beginning in July 2017. The first phase in period will begin on July 1, 2017 in the Southwest region of the state. The second phase in period will begin on January 1, 2018 in the Southeast region of the state, and the final phase in period will occur on January 1, 2019 for the remaining areas of the state.

Therefore, in conjunction with the activities occurring with CHC and the CHC waiver application, OLTL will be working with stakeholders on the development of standards, policies, procedures and revised service definitions in order to more objectively measure characteristics of the CMS rule. OLTL plans to solicit public comment on an HCBS Settings Standards bulletin in August 2016 and release the bulletin in September 2016, in addition to implementing a Participant Review tool in August 2016. OLTL will revise waiver service definitions for Residential Habilitation, Structured Day Habilitation, Prevocational Services, and Adult Daily Living, effective March 17, 2019 to require providers of these services to be in full compliance with the final rule.

Provider Monitoring

As discussed earlier, the approach, structures, and resources utilized for each program vary. Therefore, the approach to provider monitoring varies by program.

OCDEL

It is the Department's position that all services provided through the Infants, Toddlers, and Families waiver meet the requirements of home and community-based settings and are compliant with the CMS rule. For this reason, no remediation strategies are necessary and no settings will be submitted for heightened scrutiny. OCDEL will continue to monitor waiver providers to ensure individuals continue to receive services in compliant settings. Ongoing monitoring for compliance is achieved through OCDEL's annual verification process that is completed either through a verification visit or a self-verification completed by local programs utilizing standardized tools and procedures.

The verification process focuses on a common set of required indicators: child find and public awareness; procedural safeguards, evaluation for eligibility; program planning; service delivery, transition; and fiscal accountability. The verification process has three major focus areas:

1. Compliance items: state and federal regulations;
2. Program management: management of the early intervention program for continuous quality improvement; and
3. Results goals: four areas that measure direct impact of early intervention services on children and families.

The verification process is informed by ongoing review of the development of the Individual Family Service Plan (IFSP) that documents service settings as well as observation of the implementation of IFSP services by Service Coordinators and Supervisors. This same observation strategy is also used as a form of ongoing technical assistance to programs.

OCDEL issues a findings report for both verification visits and self-verification. Infant/toddler early intervention programs develop a Quality Enhancement Plan (QEP) to address non-compliances, program management areas, and results goals. The required elements of the Quality Enhancement Plan (QEP) utilized in response to identified non-compliances are:

- Goals/outcomes for non-compliance(s) as well as results goals;

- Activities to achieve goals/outcomes, target date for completion and person responsible; and
- How the goal/outcome will be measured: evidence, data source, data review schedule, and responsible persons.

The QEP is required to be submitted within 30 days of receipt of the verification findings report. The QEP must address all areas of non-compliance and include activities designed to correct non-compliance within 365 days of the issuance of the verification findings report.

The state approves the QEP. The state also conducts validation activities according to standard timelines to assure non-compliance is corrected by implementation of listed improvement activities within 365 days of issuance of findings report. This validation is achieved either onsite or through electronic sharing of evidence/documentation and conference calls. The standardized format of the QEP documents the validation process and includes sections to document the following: the QEP team review of their data, dates, and progress toward the outcomes. The results of the review as well as a section for OCDEL to document the date the outcomes were achieved and closed.

ODP

Consolidated and P/FDS Waivers

In the fall of 2017, all Consolidated Waiver and P/FDS Waiver providers will complete a self-assessment of their compliance with current applicable waivers, newly revised regulations, and policies. ODP or its designee will then complete onsite monitoring reviews of approximately 33 percent of the waiver providers for compliance with applicable waivers and regulations. The providers who are selected for onsite monitoring will be selected from the universe of waiver providers regardless of whether the self-assessment indicates compliance or noncompliance. ODP or its designee will also review all of the self-assessments for waiver providers who were not selected for an onsite monitoring and complete an onsite monitoring visit for all waiver providers who either did not complete a self-assessment or whose self-assessment indicated noncompliance.

The onsite monitoring results will identify each of the areas of noncompliance identified during the monitoring process. The Statement of Findings/Final Audit Report/Corrective Action Plan form is first issued electronically, via email, by the reviewing entity within 30 calendar days of the completed monitoring. The issued form will identify each of the areas of noncompliance identified during the monitoring process. Once the monitored provider receives the form, the provider is responsible to complete Corrective Action Plan sections of the form and return it within 15 calendar days. The information entered by the monitored provider should:

- Identify the specific action to correct each instance of noncompliance identified on the form by the reviewing entity. If there are multiple findings of the same area of noncompliance, the monitored provider may provide one response to the finding, with actions specific to the individual or location included.
- Identify a target date for the corrective action to occur by or expected to be completed by. Remediation of noncompliance is expected to be completed within 30 calendar days of receipt of the form. If the remediation has already been completed, the target date can be left blank. If this target date will exceed 30 calendar days, the monitored provider should also include an explanation of why the corrective action could not be implemented within 30 calendar days within the Corrective Action column (where the specific actions to be taken are described). If the corrective action is completed prior to submission of the Corrective Action Plan, indicate the completed date and submit documentation confirming the action with the submission of the form to the reviewing entity.

The reviewing entity will then review and return the Corrective Action Plan indicating that the plan has been approved or that further clarification and/or correction is required. Failure of the monitored provider to return the Corrective Action Plan or a revised Corrective Action Plan within 15 calendar days will result in a Directed Corrective Action Plan being issued by the reviewing entity within 10 calendar days.

All monitored providers completing a Corrective Action Plan are advised to maintain documentation of the corrective actions taken. This information will be used for future validation activities. The type of documentation needed should be in accordance with the specific monitoring process. In some instances, these corrective actions will be validated during future monitoring activities, or the monitored entities may be asked to submit documentation to the appropriate reviewing entity.

After the onsite monitoring reviews have been completed, settings that are presumed to have institutional qualities per the CMS requirements will be identified. When such settings are determined to have the qualities of a home and community-based setting, information on these settings will be submitted to CMS for heightened scrutiny. Providers determined to be ineligible will be provided appeal rights. Individuals served by providers determined to be ineligible will be notified of the provider's ineligibility and what actions participants may expect. Supports coordination entities will also be notified. This initial monitoring process will be complete in the summer of 2018.

The Department intends to publish a public notice in the fall of 2018 which will list the provider name, the county in which the setting is located, the waiver service(s) provided at the setting, and the number of individuals authorized to receive services in the setting along with the determination that the setting falls into one of the following categories:

- Ineligible for waiver reimbursement as of March 2019,
- Eligible for waiver reimbursement, or
- Eligible for waiver reimbursement and meets criteria for CMS heightened scrutiny

ODP will determine whether access issues may be created by providers who are no longer eligible/willing to provide waiver services and will ensure that participants who receive services in ineligible settings transition to willing and qualified providers. In the beginning of 2019, ODP will send a list of settings/providers determined eligible in accordance with the waiver to CMS for heightened scrutiny. Notice for the stakeholders will be published regarding the settings/providers CMS accepted as being home and community based and those that CMS denied as being home and community-based.

After this process has been completed, all Consolidated Waiver and P/FDS Waiver providers will be continuously monitored on athree year cycle through existing monitoring processes. Providers will be monitored for compliance with applicable waivers, regulations, and policies which will include compliance with the CMS Rule.

Adult Autism Waiver

In the fall of 2017, all Adult Autism Waiver providers will complete a self-assessment of their compliance with current applicable waivers, newly revised regulations and policies. ODP will complete onsite monitoring of all residential and day habilitation providers that serve participants in the Adult Autism Waiver. ODP or its designee will also complete an onsite monitoring visit for all Adult Autism Waiver providers who either did not complete a self-assessment or whose self-assessment indicated noncompliance.

The onsite monitoring results will identify each of the areas of noncompliance. Providers will be notified of the initial decision regarding the setting's eligibility electronically, via e-mail, by ODP. The monitoring results will identify each of the areas of noncompliance identified during the monitoring process. Once the monitored provider receives the monitoring results and Plan of Correction form, the monitored provider is responsible to complete a Plan of Correction and return it to ODP within 15 calendar days. If the monitored provider does not return it in 15 calendar days, ODP will send a directed Plan of Correction within 10 calendar days. ODP will then review and return the Plan of Correction indicating that the plan has been approved or that further clarification and/or correction is required. If further clarification is required, the monitored provider will have 15 calendar days to revise it and return it to ODP.

All monitored providers completing a Plan of Correction are advised to maintain documentation of the corrective actions taken. This information will be used for future validation activities. The type of documentation needed should be in accordance with the specific monitoring process. In some instances, these corrective actions will be

validated during future monitoring activities, or the monitored entities may be asked to submit documentation to ODP.

After the onsite monitoring reviews have been completed, settings that are presumed to have institutional qualities per the CMS requirements will be identified. When such settings are determined to have the qualities of a home and community-based setting, information on these settings will be submitted to CMS for heightened scrutiny. Providers determined to be ineligible will be provided appeal rights. Individuals served by providers determined to be ineligible will be notified of the provider's ineligibility and what actions participants may expect. Supports coordination agencies will also be notified. This initial monitoring process will be complete in the summer of 2018.

The Department intends to publish a public notice in the fall of 2018 which will list the provider name, the county in which the setting is located, the waiver service(s) provided at the setting, and the number of individuals authorized to receive services in the setting along with the determination that the setting falls into one of the following categories:

- Ineligible for waiver reimbursement as of March 2019,
- Eligible for waiver reimbursement, or
- Eligible for waiver reimbursement and meets criteria for CMS heightened scrutiny process.

ODP will determine whether access issues may be created by providers who are no longer eligible/willing to provide waiver services and will ensure that participants who receive services in ineligible settings transition to willing and qualified providers. In the beginning of 2019, ODP will send a list of settings/providers determined eligible in accordance with the waiver to CMS for heightened scrutiny. Notice for the stakeholders will be published regarding the settings/providers CMS accepted as being home and community based and those that CMS denied as being home and community based.

After this process has been completed, all Adult Autism Waiver providers will be continuously monitored. Providers will be monitored for compliance with applicable waivers, regulations and policies which will include compliance with the CMS rule.

Individuals, family members, and any other concerned party may report complaints, including settings that are noncompliant with the new federal requirements, to the Intellectual Disabilities Customer Service Line at 1-888-565-9435 or 1-866-388-1114 for individuals who are hearing impaired, or by electronic mail at RA-odpcontactdpw@pa.gov. ODP tracks all complaints made to this number and email address and ensures that they are resolved. For participants of the Adult Autism Waiver, participants can call 1-866-539-7689.

OLTL

The Department released an electronic provider enrollment application on January 29, 2016. This enhancement will improve the ease of submission for providers and automate processes that were previously manual and cumbersome. The electronic provider enrollment user interface will allow new and existing OLTL providers to complete their Pennsylvania Medical Assistance enrollment application online, effective January 29, 2016.

OLTL's Bureau of Provider Management's Enrollment Division accepts applications from providers electing to enroll to provide HCBS services. Prior to any enrollment the provider is required to complete the OLTL standard application form and materials. Effective July 1, 2015, the application form includes questions and information related to the HCBS final rule. Applicants that are identified as not in compliance with the final rule will be required to complete the provider self-survey and may be subject to an on-site visit by OLTL as well as submission to CMS for heightened scrutiny prior to enrollment, or may have additional steps to take to become compliant with the rule before their enrollment is considered complete. No applicants as of December 2015 have been identified as needing heightened scrutiny.

In Pennsylvania's move to CHC, services must be provided in accordance with 42 CFR §441.301(c) (4) and (5), which outlines allowable setting for home and community-based waiver services. Settings cannot be located on the grounds of a Nursing Facility, Intermediate Care Facility, and Institute for Mental Disease or Hospital; unless they meet the standards for the heightened scrutiny process established through the HCBS Final Rule and are included in the Person Centered Service Plan. The CHC-MCO must submit documentation on a quarterly basis containing a list of settings that are non-compliant.

OLTL's overall strategy will rely heavily on its existing HCBS quality assurance processes to ensure ongoing provider compliance with the HCBS rule. This will include provider identification of remediation strategies for each identified issue, and ongoing review of status and compliance. OLTL will also provide guidance and technical assistance to providers to assist providers with ongoing compliance. Providers that do not remain compliant with the HCBS final rule may be subject to sanctions ranging from probation to disenrollment.

The Quality Management Efficiency Teams (QMETs) are OLTL's regional provider monitoring agents. The QMETs monitor providers of direct services as well as agencies having delegated functions. Each regional QMET is comprised of a program specialist (regional team lead), registered nurses, social workers, and fiscal representatives. Five

teams are located throughout the state of Pennsylvania, and report directly to the OLTL QMET state coordinator.

The QMET utilizes a standardized monitoring tool and monitors providers against standards derived from Title 55, Chapter 52 of the Pennsylvania Code, provider requirements established in the approved waivers and any OLTL policies. OLTL will revise the QMET on-site monitoring tool to capture the new standards that will be published in July 2016. These revisions will include elements of a detailed look at every site, and review of the administered participant review tool. The QMET will begin monitoring to the new standards in the beginning of 2017, which will allow providers sufficient time to complete the activities necessary to come into compliance with the new standards, policies and service definitions. Compliance with final rule requirements will be assessed and validated through a regular QMET monitoring site visit. The QMET will be conducting an onsite assessment at all sites which have been identified to be in a category that requires follow-up for compliance review. These assessments will include a walk-through of the site where HCBS services occur, as well as participant file reviews and a review of the sites policies and procedures. QMET will be responsible for monitoring providers in the regions of the State that have not yet implemented CHC. Compliance will be assessed and validated through a regular QMET monitoring site visit.

With each phase-in period of CHC, the MCOs will be responsible for ensuring providers in their networks are compliant with OLTL policies related to the HCBS Final Rule. As agreed to in the CHC Agreement, the CHC-MCO must provide services in the least restrictive, most integrated setting and LTSS must be provided in accordance with 42 CFR §441.301(c) (4) and (5), which outlines allowable setting for home and community-based waiver services. This includes that CHC-MCOs shall only provide LTSS in settings that comply with federal regulations; and that settings cannot be located on the grounds of a NF, Intermediate Care Facility, and Institute for Mental Disease or Hospital, unless they meet the standards for the heightened scrutiny process established through the HCBS Final Rule and is included in the Person Centered Service Plan. The CHC-MCO must submit documentation on a quarterly basis containing a list of settings that are non-compliant.

Until CHC implementation in each region is complete, OLTL will issue a statement of findings to providers listing infractions (areas of non-compliance) and immediate need for the provider to take corrective action. OLTL will issue a Corrective Action Plan. Provider remediation activities are documented in the Corrective Action Plan which will be requested from providers by the QMETs to correct non-compliance issues. The Corrective Action Plan will provide detail about the steps to be taken to remediate issues and the expected timelines for compliance. The provider needs to demonstrate

through the Corrective Action Plan that it can meet the regulations and develop a process on how to continue compliance with the regulations.

As part of the remediation process, areas of non-compliance with the regulations are identified from the on-site review and a statement of findings is generated. The provider responds to the written statement of findings by completing a Corrective Action Plan. The Corrective Action Plan includes some of the following: action steps to address a specific finding; explanation on how the steps will remediate the finding; date when a finding will be remediated and the agency responsible person for correcting the identified problem. The provider must implement the approved Corrective Action Plan. The timeframe for conducting the Corrective Action Plan follow-up is dependent upon the dates for completion identified by the provider. QMET determines the Corrective Action Plan follow-up monitoring schedule and the method (on-site vs in office) based on the action steps that were to be completed or the area which was deemed out of compliance. Corrective Action Plans are to be followed-up on between 30 and 90 days of the last date listed under timeline for completion. The provider is notified of the type of follow-up to be performed 10 business days in advance of the follow-up monitoring. Regardless of the manner of follow-up, all documents reviewed should be of sufficient quantity and scope in order to determine if the action steps have been completed accurately, timely, and in accordance with the approved plan. If the follow-up is performed and all the action items are verified as complete the Correction Action Plan is closed. If some items remain incomplete, QMET will provide technical assistance in order to assist the provider in remediating any outstanding items and work towards closing the Corrective Action Plan. No Corrective Action Plan is closed until all action steps have been completed. Providers that are unable or unwilling to comply with their Corrective Action Plan will be dis-enrolled from providing HCBS waiver services at that setting and are required to adhere to **§ 52.61. (relating to provider cessation of services).**

(a) If a provider is no longer able or willing to provide services, the provider shall perform the following:

(1) Send written notification to each participant, the Department and other providers with which the provider works that the provider is ceasing services at least 30 days prior to the provider ceasing services.

(2) Notify licensing or certifying entities as required.

(3) Send the Department a copy of the notification sent to a participant and service providers as required under paragraph (1). If the provider uses a general notification for all participants or service providers, a single copy of the notification is acceptable.

(4) Cooperate with the Department, new providers of services and participants with transition planning to ensure the participant's continuity of care.

(b) If the provider fails to notify the Department as specified in subsection (a), the provider shall forfeit payment for each day that the notice is overdue until the notice is issued.

Providers determined to be ineligible after the Corrective Action Plan process will be provided appeal rights.

OLTL will keep a "tracker" of HCBS providers who have been deemed out of compliance with the final rule, including how many participants they serve where they are out of compliance. OLTL will be tracking these providers and participants through the Corrective Action Plan process, and or the disenrollment process to make sure no participants, and no sites are forgotten.

OLTL waiver providers are continuously monitored for compliance during a 2-year cycle per waiver requirements.

In addition, participants will be able to report any non-compliance issues through a Participant Review Tool. OLTL has developed a Participant Review Tool to be used by service coordinators during face-to-face visits that incorporates questions designed to receive participant feedback on the settings in which they receive services. Service Coordinators will conduct a face-to-face visit with the participant and complete the department issued Participant Review Tool. This will ensure that participants have a method to provide feedback and report any non-compliance issues to OLTL through their service coordinator. The participant review tool was tested in April and March of 2015. OLTL is required to upgrade their license for the IT software that the participant review tool is housed. Due to a budget impasse, OLTL has not been able to purchase the license; therefore the participant review tool is anticipated to be implemented in August 2016.

Participants also have the ability to directly report complaints through the OLTL complaint hotline. OLTL operates a Customer Service line, also known as the OLTL HelpLine. The OLTL HelpLine (1-800-757-5042) is located in the Bureau of Participant Operations, and is staffed by OLTL personnel during normal business hours. Participants, family members and other interested parties use the HelpLine to report complaints/grievances regarding the provision/timeliness of services and provider performance. Individuals calling the OLTL HelpLine with a complaint/grievance are logged into the Enterprise Information System (EIM), a web-based database, and the information is then referred to the appropriate Bureau for resolution and follow-up.

OLTL will notify participants of all findings and compliance actions that are being taken. Individuals who will have to transfer from non-compliant or presumed non-compliant settings will get advance, accessible notice through a phone call and/or visit from their service coordinator in addition to a letter, which will ensure that this important information is received and understood. OLTL will work with each participant, their families, and their HCBS service providers in assisting the participant to transfer out of the non-compliant site. The participant and their families will have the option of choosing between compliant HCBS providers and non-disability specific settings.

OLTL will be working with providers during the transition period to come into compliance with the HCBS final rule by implementing OLTL specific policies and procedures for better measurement of compliance with the final rule. A public notice will be published in January 2018, which will list all settings/providers that have been found eligible for continued waiver reimbursement and meets criteria for CMS heightened scrutiny process, including the number of participants currently receiving services in those settings.

In the spring of 2018, OLTL will send a list of settings/providers identified for heightened scrutiny to CMS for their heightened scrutiny process, including the number of participants currently receiving services in those settings. Notice for the stakeholders will be published regarding the settings/providers CMS accepted as being home and community based and those that CMS denied as being home and community based.

Continued Outreach and Engagement

States have until March 17, 2019 to come into compliance with the CMS rule. This plan will be an ongoing course of action. Each of the program offices will change its own processes and protocols based on the rule's requirements, monitor providers through a variety of mechanisms and will include stakeholder input throughout these ongoing activities. Any modifications to the transition plan will be disseminated for public input and a variety of venues will be utilized to ensure that participants, providers, advocates and the general public have an opportunity to express views.

The Department will continue to use the processes beginning on page 13 under the Outreach and Engagement section to engage stakeholders during this process.