Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Person Centered Service Plan

a. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☐	Case Manager (qualifications specified in Appendix C-3)
☑	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
	Service Coordinators will be responsible for the development of the service plan. Service Coordinators will be employed by or will be under contract with the CHC-MCO. Service Coordinators and Service Coordinator Supervisors must meet the following qualifications: • Service Coordinators must be a registered nurse (RN) or have a Bachelor's degree in social work, psychology or other related fields, or in lieu of a Bachelor's degree, have at least three (3) or more years of experience in a social service or health care related setting. Service Coordinators hired prior to the CHC zone Implementation Date must have the qualifications and standards proposed by the CHC-MCOs and approved by the department. • Service Coordinator supervisors must be an RN or have a Master's degree in social work or in a human services or healthcare field and three years of relevant experience with a commitment to obtain either a Pennsylvania social work or mental health professional license within one year of hire. Service Coordinator supervisors hired prior to the CHC zone Implementation Date (who do not have a license) must either: 1) obtain a license within their first year under the new CHC contract in their zone or 2) have the qualifications and standards proposed by the CHC-MCOs and approved by the department.
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
●	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

CHC Service Coordinators are required to be conflict free as defined in 55 PA Code, Chapter 52.28 and 42 CFR 441.301(c)(1)(vi). A Service Coordination Entity may not provide other waiver services if the Service Coordination Entity provides service coordination services under contract with a CHC-MCO.

Service Coordination agencies may provide the following vendor services under an Organized Health Care Delivery System (OHCDS) only during the 180-day continuity of care period for each implementation phase:

- Assistive Technology;
- Community Transition Services;
- Home Delivered Meals;
- Home Modifications;
- Non-Medical Transportation;
- Personal Emergency Response System (PERS); and/or
- Vehicle Modifications.

Participants are not required to receive these vendor services subcontracted through an OHCDS. Participants are able to either select any qualified provider that has contracted with the OHCDS or select any other qualified provider that is part of the CHC-MCO's provider network. The Service Coordination provider cannot require a participant to use their OHCDS as a condition to receive service coordination services from their agency.

Service Coordinators are responsible for ensuring participants are fully informed of all services available in the waiver, their right to choose from and among all willing and qualified providers that are part of the CHC-MCOs provider network, and electronically document evidence of participant choice. Service Coordinators are also responsible for providing participants with information and training on the process for selecting qualified providers of services during the PCSP development process using the provider directory which is maintained by the CHC-MCO.

Participants are also given the toll-free number of the CHC-MCO so they may contact their CHC-MCO should they have concerns about their providers or questions regarding their ability to choose providers that provide the services in their service plan. The CHC-MCO's toll-free number is provided to Participants at time of enrollment, at annual reevaluations, and during CHC Service Coordinator's participant service monitoring visits.

During the 180-day continuity of care period, the CHC-MCOs are responsible for oversight and monitoring to safeguard participants' choice of providers. At the end of each 180-day continuity of care period, the CHC-MCOs must have these types of providers enrolled as part of their provider network and ensure network capacity.

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and

be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a. The CHC-Service Coordinator provides information to the individual and to their representative, if any, in advance of the planning meeting so that he/she can make informed choices about their services and service delivery in order to effectively develop a person-centered service plan (PCSP). A PCSP is a written description of Participant-specific healthcare, Long-Term Services and Supports (LTSS), and wellness goals to be achieved, and the type, scope, amount, duration, and frequency of the covered services to be provided to a Participant in order to achieve such goals. Services and supports are based on the comprehensive needs assessment of the Participant's healthcare, LTSS and wellness needs. The PCSP will consider the current and unique psycho-social and medical needs and history of the participant, as well as the participant's functional level and support systems. The PCSP process must address the full array of medical and non-medical services needed by the Participant and supports provided by the CHC-MCO and available in the community to ensure the maximum degree of integration and the best possible health outcomes and participant satisfaction.

Prior to the PSCP meeting(s), the CHC Service Coordinator works with the participant and/or their representative to coordinate invitations and PCSP dates, times and locations. The process of coordinating invitations includes the participant's input as to who to invite to the meeting(s) and at times and locations of convenience to the participant.

The CHC Service Coordinators provide Participants and their representative, if any, with a participant orientation packet within 5 days of enrollment. The packet contains information on participant rights and responsibilities; participant choice; the role of the CHC Service Coordinator; the role of the Person-Centered Planning Team (PCPT); participant complaints; appeals and fair hearings; how to connect to other community resources; abuse, neglect and exploitation; and fraud and abuse. The packet provides Participants with a basis for self-advocacy safeguards. If the participant uses an alternative means of communication or if their primary language is not English, the process utilizes the participant's primary means of communication or an interpreter in accordance with Appendix B-8. In addition, the CHC Service Coordinator must educate the participant on the following:

- Strategies for solving conflict or disagreement within the PCPT process, including clear conflict-of-interest guidelines for all planning Participants;
- Offer informed choices to the participant regarding the services and supports they receive and from whom;
- A method for the participant to request updates to the PCSP as needed; and
- The Participant's due process and appeal rights when the Participant:
  - is denied his or her request for a new Waiver-funded service(s), including the amount, duration, and scope of service(s),
  - experiences a reduction in the amount, duration, and scope of services,
  - is denied the choice of willing and qualified Waiver provider(s),
  - experiences a decision or an action which denies, suspends, reduces, or terminates a Waiver-funded service authorized on the Participant's PCSP, or
  - is involuntarily terminated from participant direction.

The CHC Service Coordinator provides Participants and/or their representative with information and training on services and supports available to the participant and the processes for selecting qualified providers of services. The CHC-MCO shall be required to provide its Participants with LTSS Provider directories upon request, which include, at a minimum, the following information:

- The names, addresses and telephone numbers of LTSS Providers;
- Identification of the services provided by each LTSS Provider listed;
- Identification of special services, languages spoken and communication competencies, etc.; and
- Experience or expertise in serving individuals with particular medical conditions or disabilities.

b. Person-Centered Service Planning is a process directed by the participant with long-term service and support needs. The Participant has the authority to include a representative who is authorized to make personal decisions for the participant. The Participant also has the authority to include family members, legal guardians, friends, caregivers, members of the PCPT, and any others the participant or his/her representative wishes to include. The person-centered service planning process helps to identify outcomes based on the participant's goals, interests, strengths, abilities, and preferences. The process assists the participant to articulate a plan for the future and helps determine the supports and services that the participant needs to achieve these outcomes. The CHC Service Coordinator is responsible to include all of those elements into the PCSP.

The PCPT approach must provide the necessary level of support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. The CHC-MCO must annually submit and obtain Department approval of its PCPT policy on PCSP development and implementation.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a. Who develops the plan, who participates in the process and the timing of the plan:
The Participant will lead the PCPT. The PCSP process will also include individuals chosen by the Participant, who may include family members, legal guardians, friends, caregivers, and any others the participant or his/her representative wishes to include as members of the PCPT. The PCSP process helps to identify outcomes based on the participant's goals, interests, strengths, abilities, and preferences, as well as assists the participant to articulate a plan for the future and helps determine the supports and services that the participant needs to achieve these outcomes. The CHC Service Coordinator is responsible to include all of those elements into the PCSP.

Prior to the PCSP meeting(s), the CHC Service Coordinator works with the participant to coordinate invitations and PCSP/Annual Review meetings, dates, times and locations. The process of coordinating invitations includes the participant's input as to who to invite to the meeting(s) and at times and locations of convenience to the participant.

The CHC Service Coordinator ensures that the PCSP is completed prior to services being delivered. The CHC Service Coordinator will initiate a process to re-evaluate the PCSP at least annually (at least once every 365 days) and when either there is a significant change in the Participant's situation or condition or the Participant requests re-evaluation. The CHC Service Coordinator ensures that the PCSP is updated, approved, and authorized as changes occur. The CHC Service Coordinator schedules the service planning meetings at times and places that are convenient to the participant. PCSPs must be completed no later than 30 days from the date the comprehensive needs assessment or reassessment is completed.

The CHC Service Coordinator gathers information on an ongoing basis to assure the PCSP reflects the participant's current needs. The CHC Service Coordinator discusses potential revisions to the PCSP with the Participant and individuals important to the Participant. All changes to existing PCSPs must be documented in the Participant's record.

Once the PCSP is authorized by the MCO, the CHC Service Coordinator communicates the service plan content to the Participant and to the Participant's appropriate service provider or providers to ensure that service delivery matches the approved PCSP.

b. The types of assessments that are conducted:

Part of the enrollment process involves the completion of clinical eligibility determination tool to determine whether the Participant meets the Nursing Facility level of care. In addition, a physician completes a physician certification form which indicates the physician's level of care recommendation.

Once enrolled into CHC, the CHC Service Coordinator completes OLTL's standardized needs assessment which secures information about the participant's strengths, capacities, needs, preferences, health status, risk factors, physical health, behavioral health, social, psychosocial, environmental, caregiver, LTSS, and other needs as well as preferences, goals, housing, and informal supports. The comprehensive needs assessment and reassessment processes completed by the CHC-MCO must also capture the following:

- Need for traditional comprehensive care management of chronic conditions and disease management.
- Functional limitations, including cognitive limitations, in performing ADL and IADLs and level of supports required by the Participant.
- Ability to manage and direct services and finances independently.
- Level of supervision required.
- Supports for unpaid caregivers.
- Identification of risks to the Participant's health and safety.
- Environmental challenges to independence and safety concerns.
- Availability of able and willing informal supports.
- Diagnoses and ongoing treatments.
- Medications.
- Use of adaptive devices.
- Preferences for community engagement.
- Employment and educational goals.

Reassessments must be completed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, but in no case more than 14 days after the occurrence of any of the following trigger events:

- A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings, or a hospital discharge.
- A change in functional status.
- A change in caregiver or informal support status if the change impacts one or more areas of health or functional status.
- A change in the home setting or environment if the change impacts one or more areas of health or functional status.
- A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning.
- As requested by the Participant or designee, the caregiver, the provider, the PCPT or a PCPT Participant, or the Department.

In addition to the trigger events listed above, if the CHC-MCO identifies that a participant has not been receiving services for five (5) or more consecutive service days to assist with activities of daily living as indicated on the service plan, and if the suspension of services was not pre-planned, then the CHC-MCO must communicate with the participant to determine the reason for the service suspension within 24 hours of identifying the issue. If the participant's health status or needs have changed, then the CHC-MCO must conduct a comprehensive needs reassessment of the participant's needs within fourteen (14) days of identifying the issue.

c. How the participant is informed of the services available under the waiver:

The PCPT is established to identify services based on the participant's needs and preferences, as well as availability and appropriateness of services. The CHC Service Coordinator describes and explains the concept of person-centered service planning, as well as the types of services available through the Waiver and other resources. The CHC Service Coordinator also provides detailed information (described further in Appendix E) regarding opportunities for participant-directed services and responsibilities for directing those services. These discussions between the CHC Service Coordinator and the Participant will be documented in the Participant's record.

d. How the process ensures that the service plan addresses participant's desired goals, outcomes, needs and preferences:

The CHC Service Coordinator reviews the Participant's assessed needs with the Participant to identify waiver and non-waiver services that will best meet the individual's goals, needs, and preferences. In addition, CHC Service Coordinators ensure that the PCSP includes sufficient and appropriate services to maintain health, safety and welfare, and provides the support that an individual needs or is likely to need in the community and to avoid institutionalization.

The CHC Service Coordinator, along with the PCPT, utilizes the assessments, documentation obtained from direct service providers and discussions with the Participant to secure information about the Participant's needs, including health care needs, preferences, goals, and health status to develop the PCSP. This information is captured by the CHC Service Coordinator and then documented in the participant's record.

The CHC Service Coordinator reviews, in conjunction with the Participant, the Participant's services to ensure the services are adequate to meet the desired outcomes. Revisions are discussed with the Participant and incorporated into the PCSP. The Service Coordinator shares updated service information service providers. All service plan meetings and discussions with the participant are documented in the participant's record.

e. How responsibilities are assigned for implementing the plan:

The CHC-MCO must implement a written, holistic PSCP for each Participant who receives home and community-bases services. The CHC-MCO must comply with the requirements specified in 42 CFR 441.301(c)(1)-(3) and any additional requirements established by OLTL in implementing the PCSP.

The PCSP must address how the Participant's physical, cognitive, and behavioral health needs will be managed, including how Medicare coverage (if the Participant is dual eligible) will be coordinated and, how the Participants' LTSS services will be coordinated. The holistic PCSP for LTSS Participants, at a minimum, must include the following:

- Active chronic problems, current non-chronic problems, and problems that were previously controlled or classified as maintenance care but have been exacerbated by disease progression or other intervening conditions.
- Current medications.
- All services authorized and the scope, amount, duration and frequency of the services authorized, including any services that were authorized by the CHC-MCO since the last PCSP was finalized that need to be authorized moving forward.
- A schedule of preventive service needs or requirements.
- Disease management action steps.
- Known needed physical, cognitive and behavioral healthcare and services.
- All designated points of contact and the Participant's authorizations of who may request and receive information about the Participant's services.
- How the CHC Service Coordinator will assist the Participant in accessing Covered Services identified in the PCSP.
- How the CHC-MCO will coordinate with the Participant's Medicare, Veterans, BH-MCO, and other health coverage.

The PCSP for LTSS Participants must identify how their LTSS needs will be met and how their Service Coordinator will ensure that services are provided in accordance with the PCSP. The LTSS Service Plan section of the PCSP must include the following:

- All LTSS services necessary to support the Participant in living as independently as possible and remaining as engaged in their community as possible.
- Reflect that the setting in which the individual resides is chosen by the participant.
- For the needs identified in the comprehensive needs assessment, the interventions to address each need or preference, reasonable long-term and short-term goals, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes.
- Potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the Participant's maximum functioning level of well-being.
- Participant decisions around self-directed care and whether the Participant is participating in Participant-Direction.
- Communications plan.
- The scope, amount, duration and frequency that specific services will be provided.
- Whether and, if so, how technology and telehealth will be used.
- Participant choice of Providers.
- Individualized Back-Up Plan.
- Emergency Back-Up Plan.
- The person(s)/Providers responsible for specific interventions/services.

- Participant's available, willing, and able informal support network and services.
- Participant's need for and plan to access community resources and non-covered services, including any reasonable accommodations.
- How to accommodate preferences for leisure activities, hobbies, and community engagement.
- Any other needs or preferences of the Participant.
- Participant's goals for the least restrictive setting possible, if they are being discharged or transitioned from an inpatient setting.
- How the CHC-MCO will coordinate with the Participant's Medicare, Veterans, BH-MCO, other health coverage, and other supports.
- Participant's employment and educational goals.
- Emergency back-up plan.

The CHC Service Coordinator must obtain the signatures of the Participant, Participant's representative and any others involved in the planning process, indicating they participated in, approve and understand the services outlined in the PCSP and that services are adequate and appropriate to the participant's needs. A Participant may also sign indicating disapproval of the plan if the Participant disagrees with the PCSP. When this occurs, the Service Coordinator must provide the Participant with their due process and appeal rights. Every Participant must receive a copy of his/her PCSP. A copy of the signed PCSP is given to the participant as well as all members of the PCPT.

The CHC Service Coordinator, in conjunction with the Participant and PCPT, are responsible for updating the PCSP annually by performing the minimum following roles in accordance with specific requirements and timeframes, as established by OLTL:

- Conducting the annual re-assessment at least once every 365 days and whenever the Participant's needs change;
- Documenting contacts with individuals, families and providers;
- Recordkeeping;
- Locating services;
- Coordinating service coverage through internal or external sources;
- Monitoring services;
- Ensuring health and welfare of waiver Participants;
- Follow-up and tracking of remediation activities;
- Assuring information is in completed PCSP;
- Participating in PCSP reviews;
- Coordinating recommended services; and
- Reviewing plan implementation.

The Service Coordinator must communicate the service plan content to the provider or providers to ensure that service delivery matches the approved PCSP. The Service Coordinator must provide an authorization of service that includes the type, scope, amount, duration, and frequency of services to be provided and any preferences the participant has related to service delivery.

The direct service provider is responsible for providing the services in the amount, type, frequency, and duration that is authorized in the PCSP. The provider is responsible to notify the Participant's CHC Service Coordinator when the Participant refuses services or is not home to receive the services as indicated in the authorized PCSP.

The Participant is responsible to notify their service provider when they are unable to keep scheduled appointments, or when they will be hospitalized or away from home for a significant period of time. The Participant is responsible for notifying their CHC Service Coordinator when a provider does not show up to provide the authorized services and is responsible to initiate their individual back-up plan in such instances. If a participant is not capable of notifying their Service Coordinator or initiating a back-up plan a family member, or the participant's representative, will be designated the responsibility to do so.

f. How waiver and other services are coordinated:

The CHC-MCO and Service Coordinator must coordinate all necessary Covered Services and other services for Participants. The CHC-MCO and Service Coordinator must provide for seamless and continuous coordination of services across a continuum of services for the Participant with a focus on improving healthcare outcomes and independent living. These activities should be done as part of Person-Centered Service Planning and the PCSP implementation process.

The CHC Service Coordinator supports the Participant in identifying and gaining access to a continuum of services including HCBS services, as well as needed medical, social, educational, and other services, regardless of the funding source. The PCPT also reviews for the availability of informal supports in the person's community such as friends, family, neighbors, local businesses, schools, civic organizations and employers. Coordination of these services is guided by the principles of preventing institutional placement and protecting the person's health, safety and welfare in the most cost-effective manner. All identified services, whether available through the waiver or other funding sources, are outlined in the participant's PCSP, which is distributed by the CHC Service Coordinator to the Participant, PCPT and providers of service. The CHC Service Coordinator is responsible for ensuring the ongoing coordination between services in the PCSP, as well as ensuring consistency in service delivery among providers.

g. The assignment of responsibility to monitor and oversee the implementation of the service plan:

CHC-MCOs are responsible for monitoring the implementation of the PCSP, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of participants. After the initiation of services identified in the Participant's PCSP, CHC-MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the PCSP. CHC-MCOs also identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively. CHC-MCOs must develop methods for prompt follow-up and remediation of identified problems; policies and procedures regarding required timeframes for follow-up and remediation must be submitted to OLTL for review and approval. CHC-MCOs must report on monitoring results to OLTL. Furthermore, CHC-MCOs must annually submit and obtain OLTL approval of their Service Coordination staffing, Participant contact plan, caseloads, the required and the frequency of in-person contact with Participants. The CHC-MCO is responsible for on-going monitoring of PCSP implementation and of direct service providers. CHC-MCOs must conduct a formal administrative review annually for monitoring of direct service providers.

CHC Service Coordinators are responsible for documenting and monitoring at a minimum the following:

- The Participant is receiving the amount (units) of services that are in the PCSP.
- The Participant is receiving the frequency of services that are in PCSP.
- The participant receives the authorized services that are in the PCSP.

- The Participant is receiving the duration of services that are in the PCSP.

In addition, CHC service coordinators are responsible to use the standardized participant review tool designed by OLTL to capture information on Participants' health, welfare, and service needs in all HCBS settings. The tool also captures information on provider owned and operated residential settings to assist in assessing compliance with the Centers for Medicare and Medicaid Services HCBS regulation found in 42 CFR § 441.301. The overall goal of the tool is to assist SCs in their role of improving the experience of care for participants.

OLTL will monitor the following, which is outlined in 55 Pa. Code § 52.26 (service coordination services):

- Services furnished in accordance with the service plan;
- Participant access to waiver services identified in service plan;
- Participants exercise free choice of provider;
- Services meet Participants' needs;
- Effectiveness of back-up plans;
- Participant health and welfare; and
- Participant access to non-waiver services in service plan, including health services.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The PCSP process includes the identification of potential risks to the Participant.

CHC Service Coordinators initially assess risks through the standardized needs assessment that is completed during a face-to-face interview with the individual at the time of PCSP development. The CHC Service Coordinators summarize risks into categories according to health/medical, community, and behavioral risks. The CHC Service Coordinator will discuss these potential risks with the Participant and whomever the Participant chooses to have present such as the Participant's family and friends during the development of the PCSP. The CHC Service Coordinator, the PCPT, the Participant and any other individuals involved in the planning process will identify strategies to mitigate such risks that will allow Participants to live in the community while assuring their health and welfare. The Participant will sign a statement as part of the PCSP signature page agreement that indicates the CHC Service Coordinator reviewed the risks associated with the Participant's goals. This process will verify that the Participant has participated in the discussion and has been fully informed of the risks associated with his/her goals, and any identified strategies included in the plan to mitigate risk, while respecting the individual's choice and preferences in the person-centered service planning process.

The PCPT will develop both back-up plans to mitigate risks and priority arrangements to ensure the health, safety and welfare of the Participant during the PCSP development process. Back-up plans are also part of the ongoing service plan monitoring process at the CHC Service Coordinator level. All Participants are required to have individualized back-up plans and arrangements to cover services they need when the regularly scheduled direct care worker is not available. Strategies for back-up plans may include the use of family and friends of the Participants' choice and/or agency staff, based on the needs and preferences of the Participant. If the back-up plan fails, Participants may utilize the agency model to provide back-up coverage

to meet their immediate needs. The CHC Service Coordinator may reach out to and utilize other home health or home care agencies for back-up if necessary and document the details in the PCSP. In addition, the PCSP must incorporate an emergency back-up plan (emergency preparedness plan) for serious emergencies that might cause a disruption in routine services being delivered to the participant for an extended period of time. Examples include severe storms, floods, or any type of community-wide disaster that may require an evacuation from the Participant's home, or require the Participant to 'shelter in place' for a period of several days. The CHC Service Coordinator is responsible during regular monitoring to validate that the strategies and back-up plans are working and are still current. To assist in assuring the health and welfare of the individuals, Participants are instructed to contact the CHC Service Coordinators to report disruptions of back-up plans and strategies.

f. Informed Choice of Providers. Describe how Participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The CHC-MCO shall be required to provide its Participants with LTSS Provider directories in paper and electronic form upon request, which include, at a minimum, the following information:

- The names, addresses and telephone numbers of LTSS Providers;
- Identification of the services provided by each LTSS Provider listed;
- Identification of special services, languages spoken and communication competencies, etc.; and
- Experience or expertise in serving individuals with particular conditions.

The CHC Service Coordinator is responsible for ensuring Participants are fully informed of their right to choose service providers before services begin, at each reevaluation, and at any time during the year when a participant requests a change of providers. The CHC Service Coordinator will electronically document evidence of participant choice.

Participants are also given the toll-free number of the CHC-MCO so they may contact their CHC-MCO should they have concerns about their providers or questions regarding their ability to choose providers (including Service Coordination agencies) that provide the services in their service plan. The MCO's toll-free number is provided to Participants at time of enrollment, at annual reevaluations, and during CHC Service Coordinator's participant service monitoring visits.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Services may not be reduced or terminated in the absence of an up-to-date assessment of needs that supports the reduction or termination. The CHC-MCO must provide OLTL with monthly aggregate and participant-level reports on PCSP changes. OLTL may review, question and request the revisions of any PCSP.

Any deficiencies or issues identified through the review of the PCSP will be presented to the CHC MCO for remediation. The CHC-MCO will be notified through communication from OLTL staff. In the event of non-compliance with PCSP requirements and timelines, the CHC-MCO must outline a corrective action plan that addresses how and when the CHC-MCO will do the following:

- Immediately remediate all individual findings identified through the monitoring process;

- Track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance;
- Implement strategies to improve community-based Service Coordination processes and resolve areas of non-compliance or participant dissatisfaction; and
- Measure the success of such strategies in addressing identified issues.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
●	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies)*:

☑	Medicaid agency
☐	Operating agency
☑	Case manager
☑	Other (*specify):*
	CHC-MCO

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

CHC-MCOs are responsible for monitoring the implementation of the PCSP, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of participants. CHC-MCOs also shall identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively. CHC-MCOs must develop policies and procedures, including timeframes, for prompt follow-up and remediation of identified problems. These policies and procedures must be submitted to OLTL for review and approval. At a minimum, the CHC service coordinators are responsible to use the standardized participant review tool designed by OLTL to capture information on Participants' health, welfare, and service needs in all HCBS settings. The tool also captures information on provider owned and operated residential settings to assist in assessing compliance with the Centers for Medicare and Medicaid Services HCBS regulation found in 42 CFR § 441.301. The overall goal of the tool is to assist Service Coordinators in their role of improving the experience of care for participants.

CHC-MCOs must report on monitoring results to OLTL. Furthermore, CHC-MCOs must annually submit and obtain OLTL approval of their Service Coordination staffing, Participant contact plan, caseloads, the required and the actual frequency of in-person contact with Participants. At a minimum, the CHC-MCOs' Service Coordinators must meet with waiver participants at least once every three months by phone or in-person to assure that a Participant's LTSS are meeting their needs. At least two 2 of these visits must be in-person every year. The CHC-MCO is responsible for on-going monitoring of PCSP implementation and of direct service providers. CHC-MCOs must conduct a formal administrative review annually for monitoring of direct service providers. The CHC-MCO must also submit policies and procedures regarding required timeframes for follow-up and remediation to OLTL for review and approval

OLTL will monitor the following, which is outlined in 55 Pa. Code § 52.26 (service coordination services):

- Services furnished in accordance with the service plan;
- Participant access to waiver services identified in service plan;
- Participants exercise free choice of provider;
- Services meet Participants' needs;
- Effectiveness of back-up plans;
- Participant health and welfare; and
- Participant access to non-waiver services in service plan, including health services.

In addition, the Fiscal/Employer Agent (F/EA) and the Agency with Choice (AWC) vendor assist OLTL, the CHC-MCOs and their Service Coordinators in monitoring service utilization for Participants who are self-directing their services. The F/EA and the AWC vendor are required to provide monthly reports to common law employers, managing employers, the CHC-MCO, and CHC service coordinators, which display individual service utilization (both over and underutilization) and spending patterns. The F/EA is also responsible for providing written notification to the CHC Service Coordinator of any common law employer who does not submit timesheets for two or more consecutive payroll periods.

b. Monitoring Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
●	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

CHC Service Coordinators are required to be conflict free as defined in 55 PA Code, Chapter 52.28 and 42 CFR 441.301(c)(1)(vi). A Service Coordination Entity may not provide other waiver services if the Service Coordination Entity provides service coordination services under contract with a CHC-MCO.

Service Coordination agencies may provide the following vendor services under an Organized Health Care Delivery System (OHCDS) only during the 180-day continuity of care period for each implementation phase:

- Assistive Technology;
- Community Transition Services;
- Home Delivered Meals;
- Home Modifications;
- Non-Medical Transportation;
- Personal Emergency Response System (PERS); and/or
- Vehicle Modifications.

Participants are not required to receive these vendor services subcontracted through an OHCDS. Participants are able to either select any qualified provider that has contracted with the OHCDS, or select any other qualified provider that is part of the CHC-MCO's provider network. The Service Coordination provider cannot require a participant to use their OHCDS as a condition to receive service coordination services from their agency.

Service Coordinators are responsible for ensuring participants are fully informed of all services available in the waiver, their right to choose from and among all willing and qualified providers that are part of the CHC-MCOs provider network, and electronically document evidence of participant choice. Service Coordinators are also responsible for providing participants with information and training on the process for selecting qualified providers of services during the PCSP development process using the provider directory which is maintained by the CHC-MCO.

Participants are also given the toll-free number of the CHC-MCO so they may contact their CHC-MCO should they have concerns about their providers or questions regarding their ability to choose providers that provide the services in their service plan. The CHC-MCO's toll-free number is provided to Participants at time of enrollment, at annual reevaluations, and during CHC Service Coordinator's participant service monitoring visits.

During the 180-day continuity of care period, the CHC-MCOs are responsible for oversight and monitoring to safeguard participants' choice of providers. At the end of each 180-day continuity of care period, the CHC-MCOs must have these types of providers enrolled as part of their provider network and ensure network capacity.