Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age	
				Maximum Age Limit: Through Age –	No Maximum Age Limit
☐	**Aged or Disabled, or Both - General**				
	☐	Aged (age 65 and older)			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
✓	**Intellectual Disability or Developmental Disability, or Both**				
	☐	Autism			☐
	✓	Developmental Disability	18	59	☐
	☐	Mental Retardation			☐
☐	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Individuals are able to enroll in the waiver through age 59. Individuals that turn 60 while in the waiver are able to continue to receive services through the OBRA Waiver until services are no longer needed. New applicants age 60 and older will be referred to the Aging waiver.

Waiver services are limited to individuals with developmental disabilities, and who meet all of the following conditions:

1. Individuals who have a developmental disability (but do not have a primary diagnosis of either mental retardation or a major mental illness),
2. have been assessed to require services at the level of an ICF/ORC;
3. The disability manifested prior to the age of 22;
4. The disability is likely to continue indefinitely;
5. The disability results in three or more substantial functional limitations in major life activity: self-care, understanding and use of language, learning, mobility, self-direction and/or capacity for independent living.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

○	Not applicable. There is no maximum age limit
●	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit. *Specify*:
	Individuals are able to enroll in the waiver through age 59. Individuals that turn 60 while in the waiver are able to continue to receive services through the OBRA Waiver.

Appendix B-2: Individual Cost Limit

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ● **No Cost Limit**. The state does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c*. The limit specified by the state is *(select one)*:
  - ○ **%** A level higher than 100% of the institutional average. Specify the percentage:
  - ○ Other *(specify)*:
- ○ **Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ○ **Cost Limit Lower Than Institutional Costs**. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

  The cost limit specified by the state is *(select one)*:
  - ○ **The following dollar amount**: Specify dollar amount:

    The dollar amount *(select one)*:
    - ○ **Is adjusted each year that the waiver is in effect by applying the following formula:** Specify the formula:
    - ○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**
  - ○ **The following percentage that is less than 100% of the institutional average:**

	○	**Other:** *Specify:*

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. **Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	**The participant is referred to another waiver that can accommodate the individual's needs.**
☐	**Additional services in excess of the individual cost limit may be authorized.** Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	**Other safeguard(s)** *(Specify)*:

Appendix B-3: Number of Individuals Served

a. **Unduplicated Number of Participants**. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	**Unduplicated Number of Participants**
Year 1	1517
Year 2	1550
Year 3	1446
Year 4 (only appears if applicable based on Item 1-C)	627
Year 5 (only appears if applicable based on Item 1-C)	420

b. **Limitation on the Number of Participants Served at Any Point in Time**. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*:

○	**The state does not limit the number of participants that it serves at any point in time during a waiver year.**
●	**The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	**Maximum Number of Participants Served At Any Point During the Year**
Year 1	1407
Year 2	1377
Year 3	1205
Year 4 (only appears if applicable based on Item 1-C)	581
Year 5 (only appears if applicable based on Item 1-C)	389

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○	**Not applicable. The state does not reserve capacity.**
●	**The state reserves capacity for the following purpose(s).** Purpose(s) the state reserves capacity for:

Table B-3-c

	Purpose (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):
	Nursing HomeTransition/ Money Follows the Person	
	Purpose (describe):	**Purpose** (describe):
	In order to ensure the success of the Money Follows the Person Rebalancing Demonstration, Pennsylvania has reserved capacity within the OBRA Waiver to serve participants in the demonstration. MFP participants will have access to all of the services available in the OBRA Waiver. Reserved capacity was determined based on the experience in the state's Nursing Home Transition Program.	
	Describe how the amount of reserved capacity was determined:	**Describe how the amount of reserved capacity was determined:**
	Reserved capacity was determined based on the historical experience of the state's Nursing Home Transition Program.	
Waiver Year	**Capacity Reserved**	**Capacity Reserved**
Year 1	5	
Year 2	7	

	Year 3	3	
	Year 4 (only if applicable based on Item 1-C)	2	
	Year 5 (only if applicable based on Item 1-C)	2	

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

●	**The waiver is not subject to a phase-in or a phase-out schedule.**
○	**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an *intra-year* limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

●	**Waiver capacity is allocated/managed on a statewide basis.**
○	**Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:**

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

All individuals that are eligible for the waiver will be served. In the event of a waiting list for waiver services, the following entry criteria will be used:

1. Individuals who are currently receiving Medical Assistance in an institutional placement and need waiver services to transition into the community.

2. Individuals who are at risk of an institutional placement, which is defined as individuals who currently reside in the community and are at imminent risk of facility placement within 24-72 hours or less.

3. Individuals who are in the community but can wait more than 72 hours for home and community-based services.

B-3: Number of Individuals Served - Attachment #1

Waiver Phase-In/Phase Out Schedule

Based on Waiver Proposed Effective Date:

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Phase-In/Phase-Out Time Schedule.** Complete the following table:

Beginning (base) number of Participants:

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

c. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

d. Phase-In/Phase-Out Time Period. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

●	§1634 State
○	SSI Criteria State
○	209(b) State

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)***.**

●	No
○	Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☐	Low income families with children as provided in §1931 of the Act		
✓	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
✓	Optional state supplement recipients		
✓	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	●	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL Specify percentage:
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
✓	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
✓	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	Medically needy in 209(b) States (42 CFR §435.330)		
✓	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		
✓	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) *specify*:		
	All other mandatory and optional groups under the State Plan are included.		

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No**. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- ● **Yes**. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5*.
  - ○ All individuals in the special home and community-based waiver group under 42 CFR §435.217
  - ● Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:
    - ✓ A special income level equal to (select one):
      - ● 300% of the SSI Federal Benefit Rate (FBR)
      - ○ ___ % A percentage of FBR, which is lower than 300% (42 CFR §435.236)

        Specify percentage:
      - ○ $ ___ A dollar amount which is lower than 300%

        Specify percentage:
    - ☐ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
    - ☐ Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
    - ☐ Medically needy without spend down in 209(b) States (42 CFR §435.330)
    - ☐ Aged and disabled individuals who have income at: *(select one)*
      - ○ 100% of FPL
      - ○ ___ % of FPL, which is lower than 100%
    - ☐ Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) *specify*:

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217.

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

✓	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act. *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

●	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state elects to (*select one*):	
	●	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and *§*1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The state uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):				
●	The following standard included under the state plan (*Select one*):			
	○	**SSI standard**		
	○	**Optional state supplement standard**		
	○	**Medically needy income standard**		
	●	**The special income level for institutionalized persons** (*select one*):		
		●	**300% of the SSI Federal Benefit Rate (FBR)**	
		○	%	**A percentage of the FBR, which is less than 300%** Specify the percentage:
		○	$	**A dollar amount which is less than 300%.** Specify dollar amount:
	○	%	A percentage of the Federal poverty level Specify percentage:	
	○	**Other standard included under the state Plan** Specify:		
○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The following formula is used to determine the needs allowance:** Specify:			
○	Other Specify:			

ii. Allowance for the spouse only (*select one*):			
●	**Not Applicable**		
Specify the amount of the allowance (*select one*):			
○	**SSI standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:**		

	Specify:
iii. Allowance for the family *(select one)*:	
●	**Not Applicable** ***(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses. Select one:	
●	**Not applicable** ***(see instructions)*** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The state does not establish reasonable limits.**
○	**The state establishes the following reasonable limits** *Specify*:

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c-1. Regular Post-Eligibility Treatment of Income: 209(B) State. The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):			
○	The following standard included under the state plan *(select one)*		
	○	The following standard under 42 CFR §435.121 *Specify*:	
	○	Optional state supplement standard	
	○	Medically needy income standard	
	○	The special income level for institutionalized persons *(select one):*	
		○	300% of the SSI Federal Benefit Rate (FBR)
		○	% — A percentage of the FBR, which is less than 300% Specify percentage:
		○	$ — A dollar amount which is less than 300% of the FBR Specify dollar amount:
	○	% — A percentage of the Federal poverty level Specify percentage:	
	○	Other standard included under the state Plan (specify):	
○	The following dollar amount:	$	Specify dollar amount: If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance *Specify*:		
○	Other (specify)		
ii. Allowance for the spouse only (*select one*):			
○	Not Applicable (see instructions)		
○	The following standard under 42 CFR §435.121 *Specify:*		
○	Optional state supplement standard		

○	Medically needy income standard		
○	The following dollar amount: Specify dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula: *Specify:*		
iii. Allowance for the family *(select one)*			
○	Not applicable *(see instructions)*		
○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount: Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula: *Specify:*		
○	Other (specify):		
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:			
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under state law but not covered under the State's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses. *Select one:*			
○	Not applicable *(see instructions) Note: If the state protects the maximum amount for the waiver participant, not applicable must be checked.*		
○	The state does not establish reasonable limits.		
○	The state establishes the following reasonable limits *(specify)*:		

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. **Allowance for the needs of the waiver participant** (*select one*):				
○	The following standard included under the state plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional state supplement standard**		
	○	**Medically needy income standard**		
	○	**The special income level for institutionalized persons** *(select one):*		
		○	**300% of the SSI Federal Benefit Rate (FBR)**	
		○	%	**A percentage of the FBR, which is less than 300%** Specify the percentage:
		○	$	**A dollar amount which is less than 300%.** Specify dollar amount:
	○	%	**A percentage of the Federal poverty level** Specify percentage:	
	○	**Other standard included under the state Plan** Specify:		
○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The following formula is used to determine the needs allowance:** Specify:			
○	**Other** Specify:			

ii. **Allowance for the spouse only** (*select one*):	
○	**Not Applicable**
○	**The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:** *Specify:*
Specify the amount of the allowance (*select one*):	

○	**SSI standard**
○	**Optional state supplement standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
iii. <u>**Allowance for the family**</u> *(select one)*:	
○	**Not Applicable** ***(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses. Select one:	
○	**Not applicable** ***(see instructions)*** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The state does not establish reasonable limits.**
○	**The state establishes the following reasonable limits** *Specify*:

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c-2. Regular Post-Eligibility Treatment of Income: 209(B) State. The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):				
○	The following standard included under the state plan *(Select one):*			
	○	**The following standard under 42 CFR §435.121:** *Specify:*		
	○	**Optional state supplement standard**		
	○	**Medically needy income standard**		
	○	**The special income level for institutionalized persons** *(select one):*		
		○	**300% of the SSI Federal Benefit Rate (FBR)**	
		○	%	**A percentage of the FBR, which is less than 300%** Specify the percentage:
		○	$	**A dollar amount which is less than 300%.** Specify dollar amount:
	○	%	**A percentage of the Federal poverty level** Specify percentage:	
	○	**Other standard included under the state Plan** Specify:		
○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The following formula is used to determine the needs allowance:** Specify:			
○	**Other** *Specify:*			

ii. Allowance for the spouse only (*select one*):	
○	**Not Applicable**
○	**The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

	Specify:
Specify the amount of the allowance (*select one*):	
○	**The following standard under 42 CFR §435.121:** *Specify:*
○	**Optional state supplement standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ — If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
iii. <u>Allowance for the family</u> *(select one)*:	
○	**Not Applicable** ***(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses. Select one:	
○	**Not applicable** ***(see instructions)*** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○	**The state does not establish reasonable limits.**
○	**The state establishes the following reasonable limits** *Specify*:

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant *(select one)*:			
○	**SSI Standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
●	**The special income level for institutionalized persons**		
○	**A percentage of the Federal poverty level**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
○	**The following formula is used to determine the needs allowance:** *Specify formula:*		
○	**Other** *Specify*:		
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. Select one:			
●	**Allowance is the same**		
○	**Allowance is different.** *Explanation of difference:*		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:			

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the State's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

●	**Not applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The state does not establish reasonable limits.**
○	**The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

NOTE: Items B-5-e, B-5-f and B-5-g only apply for the five-year period beginning January 1, 2014. If the waiver is effective during the five-year period beginning January 1, 2014, and if the state indicated in B-5-a that it uses spousal post-eligibility rules under §1924 of the Act before January 1, 2014 or after December 31, 2018, then Items B-5-e, B-5-f and/or B-5-g are not necessary. The state's entries in B-5-b-2, B-5-c-2, and B-5-d, respectively, will apply.

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State – 2014 through 2018. The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):				
○	The following standard included under the state plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional state supplement standard**		
	○	**Medically needy income standard**		
	○	**The special income level for institutionalized persons** *(select one):*		
		○	**300% of the SSI Federal Benefit Rate (FBR)**	
		○	%	**A percentage of the FBR, which is less than 300%** Specify the percentage:
		○	$	**A dollar amount which is less than 300%.** Specify dollar amount:
	○	%	**A percentage of the Federal poverty level** Specify percentage:	
	○	**Other standard included under the state Plan** Specify:		

○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The following formula is used to determine the needs allowance:** Specify:		
○	**Other** Specify:		

ii.	**<u>Allowance for the spouse only</u>** (*select one*):
○	**Not Applicable**
○	**The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:** *Specify:*
Specify the amount of the allowance (*select one*):	
○	**SSI standard**
○	**Optional state supplement standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ — If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
iii.	**<u>Allowance for the family</u>** (*select one*):
○	**Not Applicable** ***(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*

iv. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses. Select one:	
○	**Not applicable** ***(see instructions)*** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The state does not establish reasonable limits.**
○	**The state establishes the following reasonable limits** *Specify*:

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. **Regular Post-Eligibility: 209(b) State – 2014 through 2018**. The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. **<u>Allowance for the needs of the waiver participant</u>** (*select one*):				
○	The following standard included under the state plan *(Select one):*			
	○	**The following standard under 42 CFR §435.121:** *Specify:*		
	○	**Optional state supplement standard**		
	○	**Medically needy income standard**		
	○	**The special income level for institutionalized persons** *(select one):*		
		○	**300% of the SSI Federal Benefit Rate (FBR)**	
		○	%	**A percentage of the FBR, which is less than 300%** Specify the percentage:
		○	$	**A dollar amount which is less than 300%.** Specify dollar amount:
	○	%	**A percentage of the Federal poverty level** Specify percentage:	
	○	**Other standard included under the state Plan** Specify:		

○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The following formula is used to determine the needs allowance:** Specify:		
○	**Other** *Specify:*		

ii. Allowance for the spouse only (*select one*):

○	**Not Applicable**
○	**The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:** *Specify:*

Specify the amount of the allowance (*select one*):

○	**The following standard under 42 CFR §435.121:** *Specify:*		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

iii. Allowance for the family (*select one*):

○	**Not Applicable** ***(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*

○	**Other** *Specify:*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses. Select one:	
○	**Not applicable** ***(see instructions)*** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The state does not establish reasonable limits.**
○	**The state establishes the following reasonable limits** *Specify*:

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – 2014 through 2018

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant *(select one)*:			
○	**SSI Standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The special income level for institutionalized persons**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
○	**The following formula is used to determine the needs allowance:** *Specify formula:*		
○	**Other** *Specify*:		

<table>
<tr><td></td><td></td></tr>
<tr><td colspan="2">ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.
Select one:</td></tr>
<tr><td>○</td><td>Allowance is the same</td></tr>
<tr><td>○</td><td>Allowance is different.
Explanation of difference:</td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:</td></tr>
<tr><td colspan="2">a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.
Select one:</td></tr>
<tr><td>○</td><td>Not applicable (see instructions) Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.</td></tr>
<tr><td>○</td><td>The state does not establish reasonable limits.</td></tr>
<tr><td>○</td><td>The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.</td></tr>
</table>

Appendix B-6: Evaluation / Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services.** The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is*:*	
	2	
ii.	**Frequency of services.** The state requires (select one):	
	●	**The provision of waiver services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	**Directly by the Medicaid agency**
○	**By the operating agency specified in Appendix A**
○	**By a government agency under contract with the Medicaid agency.** *Specify the entity*:
●	**Other** *Specify*:
	Currently, the local Area Agencies on Aging (AAA) Assessors conduct the initial component of the level of care assessments for individuals referred for waiver services. This practice will end September 30, 2017. Effective October 1, 2017, OLTL will be entering into a contract with an independent Assessment Entity to conduct the initial Functional Eligibility Determination. The independent Assessment Entity will also conduct reevaluations of OBRA Waiver participants as part of their transition to CHC. The independent Assessment Entity has subcontracts with local organizations to perform the initial Functional Eligibility Determinations, and is responsible for monitoring these local

	organizations to ensure that initial Functional Eligibility Determinations are completed within the required timeframes as set forth in policy. In addition a physician (M.D or D.O) completes a level of care recommendation utilizing the physician certification form. Service Coordinators, employed by MA enrolled Service Coordination Entities, conduct the annual reevaluations for participants that are already enrolled in the waiver. Service Coordinators also conduct reevaluations more frequently, if needed.

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Assessors must meet the following qualifications:
One year experience in public or private social work and a Bachelor's Degree which includes or is supplemented by 12 semester hours credit in sociology, social welfare, psychology, gerontology, or other related social sciences; or a bachelor's degree with a social welfare major; or any equivalent combination of experience and training including successful completion of 12 semester hours credit in sociology, social welfare, psychology, gerontology, or other related social sciences OR

Two years of case work experience including one year of experience performing assessments of client's functional ability to determine the need for institutional or community based services and a bachelor's degree which include or is supplemented by 12 semester hours credit in sociology, social welfare, psychology, gerontology or other related social sciences OR

One year assessment experience and a bachelor's degree with social welfare major OR

Any equivalent combination of experience or training including successful completion of 12 semester credit hours of college level courses in sociology, social welfare, psychology, gerontology or other related social sciences. One year experience in the AAA system may be substituted for one year assessment experience.

The equivalency statement under "Minimum Requirements" means that related advanced education may be substituted for a segment of the experience requirement and related experience may be substituted for required education except for the required 12 semester hours in the above majors.

The complete qualifications of the AAA Case Managers are located at the Department of Aging website at http://www.aging.state.pa.us; click on Aging Program Directives link then Home and Community Based Services Procedural Manual.

Physicians
Physicians are licensed through the Pennsylvania Department of State under the following regulations:
- Chapter 17 State Board of Medicine – Medical Doctors
- Chapter 25 State Board of Osteopathic Medicine

The applicant's physician is responsible for completing the physician's certification form (MA-51). OLTL does not contract directly with physicians to perform participant evaluations. When

a participant presents to the independent enrollment broker (IEB), the IEB sends a request to the applicant's primary care physician to fill out and return a physician's script indicating that the waiver applicant requires the level of care provided in a Nursing Facility.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Per 55 PA Code, Chapter 6210.62, an individual requires services at the level of an Intermediate Care Facility for Persons with an Other Related Condition (ICF/ORC) when they meet the following criteria:

1. Requires active treatment;
2. Has a diagnosis of an other related condition; and
3. Has been recommended for an ICF/ORC level of care based on a medical evaluation.

An Other Related Condition is defined as a severe, chronic disability (other than mental illness or an intellectual disability) that: (1) manifested before to age 22; (2) is likely to continue indefinitely; (3) and results in the impairment of either general intellectual functioning or adaptive behavior; and (4) results in substantial functional limitations in at least three of the following areas of major life activities – self-care; understanding and use of language; learning; mobility; self-direction; and capacity for independent living. "Other related conditions" may include, but are not limited to, cerebral palsy; spina bifida; epilepsy; severe physical disabilities, and autism.

Active treatment means a continuous program which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

When an applicant is applying for services the Independent Enrollment Broker (IEB) submits a physician certification form and cover letter with an explanation of the application for home and community-based services to the applicant's physician. The physician will indicate the applicant's level of care and return it to the enrollment entity. The physician certification form includes:

- Physician's recommendation of level of care required – either nursing facility clinically eligible, ICF/ORC eligible, or none of the above with an explanation
- Diagnoses
- ICD-10 code(s)
- Length of care required - short-term (180 days or less) or long-term (over 180 days)
- Physician's signature, license number and contact information

Currently, the local Area Agency on Aging (AAA) uses the Level of Care Determination (LCD), to determine the individual's disability, age of on-set and functional limitations.

e. **Level of Care Instrument(s)**. Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

●	**The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
○	**A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.** Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation.** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Initial Level of Care Determination:

The Office of Long-Term Living (OLTL) uses the following process to determine an individual's initial level of care:

- The applicant first applies for OBRA Waiver services through the statewide Independent Enrollment Broker (IEB). The role of the independent enrollment broker is to facilitate and support the participant through the enrollment process including the level of care evaluation.
- The IEB makes a referral to the independent Assessment Entity for the clinical eligibility determination and assists the applicant with obtaining a completed physician certification form from the applicant's physician (M.D. or D.O.)
- The independent Assessment Entity visits the applicant within 10 days of receiving the referral from the IEB, and uses the standardized level of care determination tool to identify information regarding the applicant's medical status, recent hospitalizations, and functional ability (ADLs and IADLs). The standardized level of care determination tool is used in all 67 counties for all individuals entering a home and community-based waiver, LIFE and to determine institutional level of care.
- The applicant's physician completes the physician certification form indicating the applicant's diagnosis and the physician's clinical eligibility recommendation. Once complete, the IEB forwards the physician's certification form to the independent Assessment Entity.
- The IEB follows the status of the clinical eligibility determination process and assists with any required communication between the applicant, the applicant's physician, and the Assessment Entity.
- The Assessment Entity is responsible for making the final clinical eligibility decision subject to OLTL oversight. In instances where the applicant's physician and the assessor differ on the final clinical eligibility determination, OLTL's Medical Director will review the collected documentation and make the final determination.

Annual Redetermination:

The participant's Service Coordination Entity is responsible for completion of the annual redetermination of level of care.

• The Service Coordinator completes the annual redetermination by visiting the participant and completing the standardized needs assessment. • The standardized needs assessment mirrors the information collected in the standardized level of care determination tool, including information on medical changes, recent hospitalizations, changes in functional status (ADLs and IADLs), and the continued need for active treatment. • The information collected in the standardized needs assessment is compared to the information collected in the individual's previous needs assessment. • The Service Coordination Entity is responsible for making the final level of care redetermination eligibility decision. As stated above, in instances where the applicant's physician and the assessor differ on the final clinical eligibility determination, OLTL's Medical Director will review the collected documentation and make the final determination. OLTL ensures that the annual redetermination process is completed on time and consistent with OLTL policies through the following methods: 1. A retrospective review of valid statistical sample of service plans as described in the Quality Improvement section of Appendix D. When issues are identified, OLTL follows up with the identified Service Coordination Entity and provides targeted technical assistance. 2. On-site monitoring of Service Coordination Entities. The QMET reviews participant records to ensure the annual reevaluation was completed within 365 days from the initial level of care determination and ensure accuracy. OLTL maintains Administrative Authority over the evaluation and reevaluation processes by monitoring the timeliness and appropriateness of LOC evaluations and reevaluations. This is referenced in the Quality Improvement section.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○	**Every three months**
○	**Every six months**
●	**Every twelve months**
○	**Other schedule** *Specify* the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

○	**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
●	**The qualifications are different.** *Specify the qualifications:*
	Have a Bachelor's Degree in social work, social science, or related field of human service, such as psychology, and one year of case management experience, or at least six months of professional

experience and at least six months as a Home and Community Based Services waiver/program participant; or

Have an Associate's Degree in social work, social science, or related field of human service, such as psychology, and two years of case management experience, or at least one year of professional experience and at least on year as a Home and Community Based Services waiver/program participant; or

Have successfully completed 12 credit hours of human services course work from an accredited college or university, and at least four years of professional experience, or at least two years of professional experience and at least two years as a Home and Community Based Services waiver/program participant.

Must have required training, including at a minimum: Office of Long-Term Living's (OLTL) Service Coordination training. Each service coordinator will be required to have 40 hours of training during the first year of employment and 20 hours annually.

Service Coordinator Supervisor must meet the same qualifications as the Service Coordinator including two years' experience as a Service Coordinator.

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify)*:

The Service Coordinator will ensure that a meeting with the participant in the participant's home takes place, to reassess the participant's need for waiver services by completing the standardized needs assessment form. Service Coordinators will be alerted to the reevaluation anniversary date through an automated notice from the Department's IT system. In addition, each Service Coordinator will be required to maintain its own tickler system to complete timely redeterminations and maintain consistency in service. The Service Coordinators are required to collect the information necessary for redeterminations every 365 days or more frequently, if needed, when there are changes in a participant's functioning and/or needs.

After the reevaluation is completed, the Service Coordinator enters the information in a service note in the Department's IT system. The redetermination information is also maintained in the participant's file at the Service Coordination Entity, and is subject for review during OLTL biennial monitoring visits and the service plan review process as described in the Quality Improvement section of Appendix D.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Documentation of the participant's initial level of care determination is electronically maintained in the Department's IT system.

In addition, copies of initial determinations and annual redeterminations are maintained in participant's file located at the Service Coordination Entity.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and

ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

PARTICIPANT FREEDOM OF CHOICE

Participants have the right to freedom of choice of providers and of choice of feasible alternatives.

The Commonwealth of Pennsylvania assures CMS that when a Nursing Facility (NF) or community resident applies for OBRA Waiver services and the participant is determined to likely need the Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) level of care, the individual will be:

• Informed by the independent enrollment entity of any feasible service delivery alternatives available under the waiver; and,

• Given the choice of receiving institutional (ICF/ORC) services, waiver services, or no services

Participant Freedom of Choice of Care Alternatives

All individuals who are determined to be eligible to receive community services in the waiver will be informed in writing, initially by the IEE and ongoing by their Service Coordinator, of their right to choose between receiving community services in the waiver, institutional (ICF/ORC) services, remain in their present program, or choose not to receive services. All eligible participants will execute his/her choice by completing the OLTL Freedom of Choice Form during the initial enrollment process and on-going as part of the person-centered planning process. Documentation is made in the participant's file that the form was completed; completed forms are maintained in the participant's file.

Participant Freedom of Choice of Providers

The independent enrollment entity is responsible for ensuring that all individuals who are determined eligible for waiver services are given a list of all enrolled Service Coordination Entities, and documenting the participant's choice of service coordinator on the OLTL Service Provider Choice Form. In addition, the enrollment entity is responsible for educating participants of their right to choose from any qualified provider, the opportunity to self-direct some or all of their direct services, and the ability to change providers at any time. The enrollment entity will give each participant information about the Services and Supports

Directory, a web-based listing of all enrolled providers. The information contained in the Services and Supports Directory will also be made available in a non-web-based format, as necessary or when requested. Notation is made in the participant's record of receipt of the form; completed forms are maintained in the participant's file with the Service Coordination Entity. OLTL monitors participant receipt of the forms as part of its biennial provider reviews.

The Service Coordination Entity is responsible for ensuring participants are fully informed of their right to choose service providers at the time of development of the initial Individual Service Plan, annually thereafter, and at any time during the year when a participant requests a change of providers. The Service Coordination Entity is responsible for providing the participant with the OLTL Service Provider Choice Form, and ensuring that the participant has reviewed and signed the form. Notation is made in the participant's record of receipt of the form; completed forms are maintained in the participant's file with the Service Coordination Entity. OLTL monitors participant receipt of the forms as part of its biennial provider reviews

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Service Coordinators maintain copies of the choice forms in the participant's record located at the Service Coordination Entity.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Service Coordination Entities and Direct Service Providers will make waiver documents available in different languages upon request, at no charge. Language assistance will be provided by the provider without charge. In addition, sign language services must be made available, at no charge, to individuals who are deaf or hard of hearing.

All providers are required to have and implement policies and procedures for participants with limited English proficiency to ensure meaningful access to language services as required by 55 Pa. Code Chapter 52. In addition, OLTL's contract with the Independent Enrollment Entity (IEE) requires the IEE to provide enrollment documents as well as language assistance available upon request, at no charge. Sign language services must also be made available, at no charge, to individuals who are deaf or hard of hearing.

Providers are required to provide a copy of their LEP policies and procedures to OLTL prior to enrollment as an HCBS waiver provider. In addition, as part of the monitoring reviews conducted by QMET, documentation of the LEP policies and procedures are reviewed. Corrective action plans are developed if the documentation cannot verified.

OLTL has also designated an LEP Coordinator to monitor any complaints from providers, participants, etc. relating to the lack of LEP services. Follow-ups are conducted to ensure that the necessary services are received.