

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The following are the audit and financial review requirements to ensure the financial integrity of the waiver program as specified in PA Code §52.43 Audit Requirements:

1. Providers shall comply with the Federal audit requirements as specified in Section 74.26 of 45 CFR (relating to non-Federal audits).
2. Providers who meet certain thresholds as specified in OMB Circular A-133, as revised, and the Department of Human Services' (DHS) Annual Single Audit Supplemental Publication are required to have an audit in compliance with the Single Audit Act of 1984, P.L. 98-502, as amended, and to complete DHS's annual Single Audit Supplement publication.
3. Providers who are not required to comply with the Single Audit Act of 1984 during any program year shall maintain auditable records in compliance with PA Code §52.43.
4. DHS may request that a provider have the provider's auditor perform an attestation engagement; DHS or DHS' designee may perform an attestation engagement; or DHS may request that the provider's auditor conduct a performance audit in accordance with the following:
 - a) Government Auditing Standards issued by the Comptroller General of the United States or the Generally Accepted Government Auditing Standards (GAGAS).
 - b) Standards issued by the Auditing Standards Board.
 - c) Standards issued by the American Institute of Certified Public Accountants.
 - d) Standards issued by the International Auditing and Assurance Standards Board.
 - e) Standards issued by the Public Company Accounting Oversight Board.
 - f) Standards of successor organizations to those organizations in paragraphs a. through e. above.

Providers are required to follow the provisions of 55 PA Code Chapter 52.43(n), which states that "a provider shall retain records that relate to litigation of the settlement of claims arising out of performance or expenditures under a waiver or the Act 150 program to which an auditor has taken exception, until the litigation, claim or exceptions have reached final disposition or for a period of at least 5 years from the provider's fiscal year-end, whichever is greater." See 55 PA Code Chapter §52.43 at the following link: http://www.pacode.com/secure/data/055/chapter52/055_0052.pdf

If the provider has a settlement of claims as a result of litigation, then the provider must retain auditable records 5 years from the end date of the litigation or 5 years from the provider's fiscal year-end, whichever is greater. Additionally, the provider must retain records beyond the 5 year period if

DHS or another State or Federal agency has unresolved questions regarding costs or activities of the provider.

Payments to providers are also controlled by edits built into the Commonwealth's MMIS system known as PROMISE™. Claims for services are matched against the eligibility system (CIS) so that payments are not made for recipients that have not been approved for Medicaid and for the waiver. Additionally, the PROMISE™ system will not pay claims if a participant does not have either the service or the provider included in the approved service plan for the recipient in the HCSIS system.

The Office of Long-Term Living's (OLTL), Quality Management Efficiency Teams (QMET) conduct ongoing monitoring of financial records that document the need for and the cost of services rendered by providers under the waiver. QMET completes a TSADF claims review of waiver providers as part of the regulatory monitoring which includes initial and follow-up monitoring. Comprehensive on-site monitoring of HCBS providers are conducted every two (2) years. Additional time frames for more frequent monitoring are determined by the existence of an active corrective action plan (CAP), provider history (complaints, incident reports, etc.), provider type and as identified by the OLTL.

Claims are reviewed by QMET to verify that billing is supported in the correct type, scope, amount, duration and frequency (TSADF) as written in the individual service plan (ISP). The ISPs are developed by service coordination entities along with participant input and based upon an assessment of the participants needs. Monitoring of the financial records provides the opportunity to reevaluate the ISPs by looking at utilization of services to identify trends such as underutilizing services and overutilization.

In the agency model of service, the ISP is broken down by service for the Direct Service Providers (DSP) on a Service Authorization Form (SAF). The SAF lists all of the necessary information required to perform the services being ordered and based on the provider type i.e.: personal assistance service, RN Services, etc.

At a DSP review, QMET requests all SAFs and timesheets for a statistically significant sample of billing. The information requested is for a one year period ending with the month prior to the month of the review. The SAFs and timesheets are compared to confirm that the services ordered were the services provided. Any deviations between the timesheets and SAFs that are not documented will result in a finding and the provider will be cited. Other issues that could result in a provider being cited are: the provider does not maintain documentation in the record of the SAF, the timesheet is not clear and TSADF cannot be determined, timesheets are missing etc.

OLTL does not review in detail any internal controls, ledgers, costs, or budgeting documentation at the agencies. OLTL does not reimburse providers based upon costs or conduct cost settlements for its HCBS waiver services; services are reimbursed based upon the established MA fee schedule.

The HCBS Field Operations Manager is responsible to direct five (5) regional teams which monitor and report data on provider compliance. These regional teams are collectively called QMET. The majority of QMET is comprised of contract staff. The regional teams include financial representatives that are responsible in conjunction with other team members to perform monitoring reviews.

Responsibilities of the financial representative include, but not limited to, assessing whether or not the provider entity has maintained sound fiscal practices, billed DHS properly, and used DHS funds in accordance with program guidelines, determine the appropriateness of costs claimed for DHS

subsidy, determine whether an entity is managing and utilizing its resources economically and effectively and identify the causes of inefficient or uneconomical practices.

Depending on the findings of the QMET reviews, remediation may include:

- Suspending claims pending review prior to payment.
- Review of provider's records.
- Review of provider's written billing policies/procedures.
- Sanctions, prohibition or disenrollment from providing services.
- Prohibition from serving new participants.

When overpayments, or payments unsupported by proper documentation are identified during monitoring, the following steps are taken by the Division of Provider and Operations Management. Providers will receive a series of letters outlining what steps they must take, within a specified time frame, to correct the overpayment. The first letter outlines the overpayments that have been identified and allows the agency to submit further supporting documentation to validate the payment received. The provider is given a 15 day window to comply with this request. If the provider cannot or does not respond, a second letter outlines that they have an additional 15 days to comply or the Department will begin to recover the identified overpayments through either adjustments to future claim payments or a lump sum payback. If OLTL receives no response or the provider agrees with the overpayment, the Department discusses payment methods with the agency and either allows a one-time payment via check, a monthly payback via check, or reduces future payments to that agency until the full amount of the overpayment is recovered.

Regulation § 52.43(e) states that the Department may request a performance audit to be performed by the provider's financial professional in accordance with any of the standards listed in 55 Pa. Code § 52.43(c).

In order to assure that each claim is processed in accordance with the approved waiver OLTL-specific edits and audits were developed and are maintained for the State's CMS certified Medicaid Management Information System (MMIS). PROMISE™ is the MMIS utilized for claims processing. Claims that are incomplete or contain invalid Information are denied to ensure compliance with what is specified in the approved waiver.

A provider which is not required to meet the threshold for an annual audit will maintain auditable records. The provider will maintain books, records and documents that support the type, scope, amount, duration and frequency of service provision.

Providers are subject to on-site reviews every two (2) years. Additional time frames for more frequent monitoring are determined by the existence of an active corrective action plan (CAP), provider history (complaints, incident reports, etc.), provider type and as identified by the OLTL.

Review of the provider's cost accounting systems is minimal. QMET gathers, from the provider, an independent audit (if completed) and financial documentation such as balance sheets, tax returns and bank statements. QMET does not perform any formal testing/review of these documents. These documents are viewed onsite by the Financial Representative(s), and if there are any unusual items or obvious cash flow and/or going concern issues, QMET it to make note. QMET does not review in detail any internal controls, ledgers, costs, or budgeting documentation at the agencies.

Providers may also be selected for a GAGAS performance audit by the DHS Bureau of Financial Operations.

All allegations of suspected fraud and financial abuse are directed to the Bureau of Program Integrity (BPI) within the Department of Human Services. Instances are reported by calls, letters and emails from providers, participants, care workers, witnesses etc. In addition to reports that are received directly to BPI, QMET staff may discover potential instances of fraud and abuse during the course of on-site monitoring. Pertinent information is compiled by QMET and forwarded on to BPI for investigation.

Please note, OLTL does not license or prior authorize services.

APPENDIX I-2: Rates, Billing and Claims

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

OLTL's Medical Assistance fee schedule rates are developed using a market-based approach, using the most current available market data, as opposed to reliance solely on provider-specific cost data. In the few cases where provider data is available, it is reviewed to help identify certain cost components and to inform the fee development process, but no fees are set solely on reported provider costs.

After allowable cost components are identified and market data are reviewed, the process used to calculate the MA fee schedule rates starts with the assumed direct care worker salary expenses. Consideration for all employee-related expenses and productivity adjustments are loaded on top of the wage to calculate a full hourly cost for the direct care worker. Once this amount is established, other program indirect costs are factored in, followed lastly by the loading on of administration expense considerations. The resulting hourly amount is then converted to the appropriate unit definition for the given procedure code (e.g., 15 min, day). Please refer to the unit definitions by procedure code in the rate table found at the link below. These unit definitions are consistent with the units of service displayed in Appendix J.

After a rate is developed, OLTL develops geographical fees to reflect service delivery costs in regions across the Commonwealth. Region 1 represents Pittsburgh and surrounding counties, Region 4 represents Philadelphia and surrounding counties, Region 3 represents Harrisburg and surrounding counties and Region 2 represents all other counties. Fee schedule rates vary depending on the geographic region in which the service is provided. The link to OLTL's current rate schedule is:
http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_220889.pdf.

Please refer to the following link for a description of the regions and a summary of the rate-setting methodology: <http://www.pabulletin.com/secure/data/vol42/42-23/1058.html>.

Fee schedule rates are established by OLTL to fund services at a level sufficient to ensure participant access to services and to encourage sufficient provider participation so that participants have provider choice, while at the same time ensuring cost effectiveness and fiscal accountability.

The fee schedule rates are not adjusted for acuity determination considerations, as differences in acuity are reflected through the use of different staffing ratios or intensity levels for some services. In years when a fee schedule re-base has not been performed, OLTL reviews the fee schedule and applies a cost of living (i.e., inflation factor) adjustment, if needed. No other adjustments were considered to develop the final fee schedule rates.

Rates for the following services are on the waiver fee schedule: Adult Daily Living Services (Basic and Enhanced), Behavior Therapy, Benefits Counseling, Career Assessment, Cognitive Rehabilitation Therapy, Community Integration, Counseling Services, Employment Skills Development, Home Health Services (Nursing, Occupational Therapy, Physical Therapy and Speech and Language Therapy), Job Coaching, Job Finding, Nutritional Consultation, Personal Assistance Services (agency and participant-directed), Personal Assistance Services – participant-

directed overtime, Prevocational Services, Residential Habilitation, Residential Habilitation Enhanced staffing, Respite (agency and participant-directed), Respite – participant-directed overtime, Service Coordination, Structured Day Habilitation, and Structured Day Habilitation Enhanced Staffing.

Participant-directed overtime rates were established through the development of standard rate ranges as described above for personal assistance and respite services. The resulting waiver fee schedule rate was multiplied by 1.5 to obtain the overtime rate. The overtime rate is only paid to participant-employed direct care workers who do not live in the same residence as the participant and for hours worked over 40 hours per week.

Home Adaptations, Assistive Technology, Specialized Medical Equipment and Supplies, Vehicle Modifications, Non-Medical Transportation, Community Transition Services, and Personal Emergency Response Services are all vendor services; vendors may charge what is “usual and customary” for the general public. OLTL does not determine the provider’s Usual Customary Charge (UCC). If OLTL had cause to investigate, OLTL would request the provider’s documentation to support their UCC (such as their fee schedule), and any other records to show that the provider actually applied the UCC charged to the commonwealth to individuals in the general public.

OLTL provides stakeholders and the general public input on rates in a variety of ways. Feedback is solicited through various forums, including convening a provider workgroup, conducting on-site provider interviews, issuing an all-provider survey, and providing updates at the Long-Term Care Subcommittee of the Medical Assistance Advisory Committee (MAAC). In addition, once rates are determined, OLTL publishes a rate notice in the PA Bulletin with a 30-comment period. Comments received are considered in subsequent revisions to the MA Program Fee Schedule.

When the participant chooses to self-direct some or all of their services, the F/EA is responsible for informing the participant of the established rate for that service.

While monitoring providers on-site, the Quality Management Efficiency Teams request all mileage sheets and/or receipts from buses, taxis or other modes of transportation related to non-medical transportation. The Financial Representative then compares them to the amount billed and paid. Staff then reviews the participant files for the individualized assessment which was performed determining the participants need, and contact notes in HCSIS or SAMS to verify that the service approved was provided.

Non-Medical Transportation services cannot be authorized for a participant that is receiving Residential Habilitation services. The Bureau of Participant Operations ensures that both Residential Habilitation and Non-Medical Transportation are not mutually present on service plans at time of review. BPO also performs random reviews of those ISPs that go through the auto approval process. In addition, during the biennial provider monitoring process, QMETs review a statically significant sample of ISPs and correlated billing documents.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state’s claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers must follow PA Code Chapters 52 and 1101 when submitting claims for payment.

Providers are reimbursed retrospectively based on services provided.

Providers must submit claims through PROMISe™, DHS's MMIS system. This system is administered by the Office of Medical Assistance Programs (OMAP) and the Department's Bureau of Information Systems (BIS).

In order to be paid for submitted claims, providers must be enrolled as Medical Assistance providers and entered as such into PROMISe™.

PROMISe™ verifies participant information in the Client Information System (CIS), which contains MA participant's eligibility information, such as the participant's Master Client Index (MCI) number, name, the participant's eligibility status and effective eligibility dates.

PROMISe™ also verifies with HCSIS that the provider(s) and service(s) on the claim are included in the participant's approved waiver service plan.

Service Coordination providers that also serve as Organized Health Care Delivery Systems (OHCDS) providers (further outlined in Appendix I-3, g. ii. below) may serve as the fiscal intermediary for certain specified services. The OHCDS whether subcontracting or directly reimbursing the cost of the service provided by a provider or vender may not bill more than the actual cost of the service. The OHCDS will bill through PROMISe™ and all of the edits, systems checks, etc. as listed above will pertain.

Billing for recipients that choose to self-direct their services is more fully outlined in Appendix E. For Participant-Directed Personal Assistance Services, the F/EA will submit claims to PROMISe™ on behalf of the waiver participant employer. These claims will be billed through PROMISe™, again going through all edit and system checks outlined above. The claims will only be submitted for appropriately approved direct care worker timesheets.

c. Certifying Public Expenditures (select one):

<input checked="" type="radio"/>	No. State or local government agencies do not certify expenditures for waiver services.
<input type="radio"/>	Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid. <i>Select at least one:</i>
<input type="checkbox"/>	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). <i>(Indicate source of revenue for CPEs in Item I-4-a.)</i>
<input type="checkbox"/>	Certified Public Expenditures (CPE) of Local Government Agencies. Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are

eligible for Federal financial participation in accordance with 42 CFR §433.51(b).
(Indicate source of revenue for CPEs in Item I-4-b.)

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for Federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

OLTL ensures that the individual was eligible for Medicaid waiver payment on the date of service, the service was included in the participant's approved service plan, and the services were provided through the use of the following strategies and tools:

Billing validation is done first through PROMISE™. PROMISE™ verifies participant information in the Client Information System (CIS), such as the participants Master Client Index (MCI) number, name, the participants eligibility status and effective eligibility dates. PROMISE™ also verifies that the provider(s) and service(s) on the claim are enrolled providers of the services and the services are in the OBRA Waiver.

After validation of the above listed items occurs, the claim information is sent to the Home and Community Services Information System (HCSIS) to be verified against the participants ISP. If any of the information on the PROMISE™ claim is in conflict with the ISP, HCSIS sends an error code to PROMISE™. PROMISE™ then suspends or rejects the claim. This fiscal accountability of services rendered provides an upfront monitoring of eligibility status and authorized services as per the approved ISP. Resolutions of denied or suspended claims occur through error code notification.

In addition to the above electronic process, fiscal accountability is also achieved through provider agreements with qualified providers/agencies, through the maintenance of appropriate evaluations and reevaluations, and financial records documenting the need for and the cost of services provided under the waiver.

OLTL staff also conducts ongoing monitoring of financial records that document the need for and the cost of services provided under the waiver. As part of the comprehensive on-site monitoring, participant files and service notes are reviewed to ensure that the services authorized have been received.

Claims are reviewed to verify that billing is supported in the correct type, scope, amount, duration and frequency (TSADF) as written in the individual service plan (ISP). In the agency model of service, the ISP is broken down by service for the Direct Service Providers (DSP) on a Service Authorization Form (SAF). The SAF lists all of the necessary information required to perform the services being ordered and based on the provider type i.e.: personal assistance service, RN Services, etc. This provides an additional check against Service Coordinators who are responsible for ensuring the proper information is entered into HCSIS correctly so providers can bill timely and accurately.

All unsupported overpaid claims identified by the TSADF review are reported to the Division of Provider and Operations Management for recoupment purposes.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

APPENDIX I-3: Payment

a. Method of payments — MMIS (select one):

<input checked="" type="radio"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="radio"/>	<p>Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.</p>
<input type="radio"/>	<p>Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:</p>
<input type="radio"/>	<p>Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:</p>

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

<input type="checkbox"/>	The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
<input checked="" type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input type="checkbox"/>	<p>The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:</p>
<input type="checkbox"/>	<p>Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity. Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.</p>

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- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

<input checked="" type="radio"/>	No. The state does not make supplemental or enhanced payments for waiver services.
<input type="radio"/>	Yes. The state makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

- d. Payments to state or Local Government Providers.** *Specify whether state or local government providers receive payment for the provision of waiver services.*

<input checked="" type="radio"/>	No. State or local government providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i>
<input type="radio"/>	Yes. State or local government providers receive payment for waiver services. <i>Complete item I-3-e.</i> Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish. <i>Complete item I-3-e.</i>

- e. Amount of Payment to State or Local Government Providers.**

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

<input type="radio"/>	The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.
<input type="radio"/>	The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

<input type="radio"/>	<p>The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.</p> <p>Describe the recoupment process:</p>

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

<input checked="" type="radio"/>	<p>Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.</p>
<input type="radio"/>	<p>Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.</p> <p>Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.</p>

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

<input checked="" type="radio"/>	<p>No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.</p>
<input type="radio"/>	<p>Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).</p> <p>Specify the governmental agency (or agencies) to which reassignment may be made.</p>

ii. **Organized Health Care Delivery System.** *Select one:*

<input type="radio"/>	<p>No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.</p>
<input checked="" type="radio"/>	<p>Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.</p> <p>Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:</p>

If a service coordination entity is enrolled as an OHCDS, it may subcontract the services. In its subcontracting activities, the provider must have a written agreement containing the OHCDS and the subcontractor's duties, responsibilities and compensation.

If an OHCDS subcontracts with an entity to provide a vendor good or service, the OHCDS shall ensure the entity complies with 55 Pa. Code Chapter 52.51 related to vendor good or service payment. See <http://www.pacode.com/secure/data/055/chapter52/chap52toc.html>

OHCDS process:

- a. The OHCDS bills the Department for the vendor good or service and then pays the subcontractor. The OHCDS is responsible to ensure that the subcontracting agency is only charging what the good or service costs the general public, and the OHCDS may not charge an administrative fee or any additional costs. Entities eligible for designation as OHCDS for services within this waiver are service coordination entities, all of which render at least one Medicaid service directly (Service Coordination) utilizing its own employees.
- b. Eligible entities may request enrollment. Such requests are reviewed and approved by OLTL prior to any service provided through the OHCDS arrangement.
- c. As described in Appendix D, individuals are fully informed of their right to choose from all willing and qualified providers and are not required to utilize the OHCDS arrangement. Providers who do not wish to affiliate with an OHCDS may always directly enroll as a provider with the Department.
- d. Through robust provider/SC oversight and monitoring, as well as through information garnered through service plan and claims data, OLTL monitors services provided through OHCDS to ensure that the OHCDS has contracted only with providers meeting established minimum qualifications.
- e. Through these oversight mechanisms, OLTL will also ensure that the arrangements meet State and Federal requirements
- f. The full amount of service dollars is passed through for the provision of service.
- g. The State assures financial accountability when an OHCDS arrangement is used by monitoring individual service plans and claims paid to the OHCDS entities through the comprehensive provider and SC monitoring processes performed by OLTL. The state ensures that the payment to the OHCDS does not result in excessive payments through the established process of paying only the cost of the service or good provided.

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

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| <input checked="" type="radio"/> | The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services. |
| <input type="radio"/> | The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. |

	Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
○	This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

APPENDIX I-4: Non-Federal Matching Funds

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. *Select at least one:*

<input checked="" type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid Agency
<input type="checkbox"/>	<p>Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.</p> <p>If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:</p>
<input type="checkbox"/>	<p>Other State Level Source(s) of Funds.</p> <p>Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:</p>

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select one:*

<input checked="" type="radio"/>	Not Applicable. There are no local government level sources of funds utilized as the non-federal share.
<input type="radio"/>	<p>Applicable</p> <p><i>Check each that applies:</i></p>
<input type="checkbox"/>	<p>Appropriation of Local Government Revenues.</p> <p>Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:</p>
<input type="checkbox"/>	<p>Other Local Government Level Source(s) of Funds.</p> <p>Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any</p>

		matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

- c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds . *Select one:*

●	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.
○	The following source(s) are used. <i>Check each that applies.</i>
<input type="checkbox"/>	Health care-related taxes or fees
<input type="checkbox"/>	Provider-related donations
<input type="checkbox"/>	Federal funds
	For each source of funds indicated above, describe the source of the funds in detail:

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

<input type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual.
<input checked="" type="radio"/>	As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

In accordance with 42 CFR 441.310(a)(2), the Commonwealth does not pay the cost of room and board. The fee schedule developed for all waiver services are based solely on service costs and does not include consideration for room and board. These payments are processed through the Commonwealth's MMIS system, PROMISE™, and the cost of room and board is not included.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.

Select one:

<input type="radio"/>	<p>No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.</p>
<input type="radio"/>	<p>Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.</p> <p>The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<input type="radio"/>	

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

- a. **Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

<input checked="" type="radio"/>	No. The state does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="radio"/>	Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

i. **Co-Pay Arrangement**

Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge
	<i>Specify:</i>

ii **Participants Subject to Co-pay Charges for Waiver Services.**

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

- iii. **Amount of Co-Pay Charges for Waiver Services.** The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	Basis

--	--	--

iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

<input type="radio"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

<input checked="" type="radio"/>	No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
<input type="radio"/>	Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded; and (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64: