Purpose, Scope and Background

The Office of Long-Term Living (OLTL) has been working closely with the Centers for Medicare & Medicaid Services (CMS) on several waiver amendments and renewals. The purpose of this bulletin is to provide clarification on a number of policy issues that are necessary to implement the OLTL Waiver provisions. This Bulletin applies to all 1915(c) Medicaid Home and Community-Based Services (HCBS) Waivers and the Act 150 program administered through the Office of Long-Term Living, and rescinds and replaces Office of Long-Term Living Bulletin number 05-10-04, 51-10-04, 55-10-04, 59-10-04 issued on July 6, 2010. Although this Bulletin makes references to state-funded programs, such as Options, its primary purpose is to provide clarification regarding OLTL Waiver policies. This Bulletin is divided into two main sections: Section I, entitled, “All OLTL Waivers and the Act 150 Program,” applies to those programs. Section II, entitled, “Aging Waiver,” applies exclusively to the Aging Waiver.

Section I. All OLTL Waivers and the Act 150 Program

MA-51/ Physician Certification

In order to determine clinical eligibility for an OLTL HCBS waiver, a physician is required to certify that an individual meets the required level of care for a nursing facility. This process has been applied inconsistently across the commonwealth. In most areas an MA-51 Physician Certification form was required, but in counties that were designated as “Community Choice” areas, a physician’s prescription was permitted. For the purposes of consistency and simplicity, an MA-51 form is no longer required to determine clinical eligibility for OLTL HCBS waiver programs. The agency responsible for obtaining the physician certification (i.e., local Area Agency on Aging or Independent Enrollment Broker) may instead obtain and rely upon a physician prescription indicating that the waiver applicant requires the level of care provided in a Nursing Facility.
The physician’s prescription should indicate that the applicant clinically qualifies for waiver services by stating at a minimum (note: exact wording not required): “Requires support provided through home- & community-based services or a nursing facility.” Note also that the annual reevaluation (the reapplication/recertification) for OLTL waivers requires neither an MA-51 nor a physician’s prescription.

**Criminal History Background Checks in the Participant-Directed Services in OLTL Home and Community-Based Programs**

Criminal history background checks are required for all personal assistance workers and support workers employed by a consumer in participant-directed services.

All prospective participant-employed workers must request a criminal history background check through the Fiscal/Employer Agent (F/EA). The F/EA is responsible for obtaining the background check from the Pennsylvania State Police (PSP) at no cost to the participant or worker. Note that if the prospective worker has not lived in Pennsylvania for the last two years, a national criminal background check must be obtained from the Federal Bureau of Investigation (FBI). The Fiscal/Employer Agent is also responsible for obtaining and paying for ChildLine clearance if the worker is providing services in a home with a minor child in residence.

**Services Outside the Home**

The ability to drive an automobile or engage in social or community activities outside the home does not disqualify a participant from participation in an OLTL Waiver. The purpose of the HCBS waivers is to preserve and encourage full integration and engagement of long-term living participants in their neighborhoods and communities. Requiring older adults or individuals with physical disabilities to forfeit mobility or community involvement and remain confined to their homes in order to attain or maintain OLTL Waiver eligibility is not a requirement and defeats the purpose of HCBS.

**Provider Certification**

Home- and community-based waiver participants must be allowed to obtain services from any willing and qualified provider of a service who is enrolled as a Medical Assistance provider. A “qualified waiver provider” means an individual or entity deemed qualified and enrolled by OLTL in the waiver program for the service that the provider renders.

AAAs and Service Coordination Agencies may not impose additional qualifications or requirements on providers beyond those specified in the terms of the federal waiver approved by CMS. Examples of requirements not permitted under the terms of the OLTL Waivers: provision of surety bonds by providers wishing to participate in Medical Assistance or demonstration that the provider maintains a business office within county limits. Additionally, AAAs or Service Coordination Agencies may not limit the number of qualified providers enrolled in an OLTL Waiver.
Choice of Providers

Individuals receiving OLTL HCBS services benefit from “choice of providers,” i.e., participants have the ability to choose from a complete list of qualified providers for any services authorized in their service plan, regardless of service model. It is the responsibility of the enrolling and service coordination agencies to provide participants at the time of the participant’s enrollment (and on a periodic basis thereafter) with a list of all providers deemed qualified and enrolled in the program by OLTL. Participants in OLTL HCBS are not required – nor can they be compelled -- to use a specific provider or to use one provider for all services. (See Attachments 4 and 5 regarding Provider Choice Protocol and Form).

AAAs must use a complete, randomized list of providers certified by OLTL to provide Aging Waiver services in the AAA’s Planning and Service Area. This list may be provided by AAAs to participants in electronic or paper format. This list will be generated periodically by the AAA according to the Provider Choice Protocol at Attachment 3.

Services Offered by Waiver Providers

This Bulletin immediately rescinds and replaces the requirement in Chapter II of the Attendant Care Program Requirements mandating participating providers to offer all of the services available through the Attendant Care Act 150 and Attendant Care Waiver Programs. Providers of all OLTL HCBS programs are permitted to choose which services they will provide among the menu of services available in the program -- they are not required to provide all of the services.

Personal Emergency Response System (PERS)

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable electronic “help” button. The system is connected to the person's phone and programmed to signal a response center once the “help” button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals (1) who live alone or who are alone for significant parts of the day, (2) have no regular caregiver for extended periods of time, or (3) who would otherwise require extensive routine supervision.

One-time installation of the PERS unit is covered under the W1718 procedure code. Repairs, maintenance and replacement are covered under the W1722 procedure code. The rate for the installation and repair codes are the same as the monthly maintenance fee.

Telephony Services

OLTL accepts and strongly encourages telephony time & attendance system electronic records in place of participant-signed paper timesheets. OLTL requires that acceptable telephony systems:

- Have the capability to schedule and modify worker hours and services
- Allow a start time window (allow call-in within 5-15 minutes of scheduled time)
- Allow an end time window (allow call-out within 5-15 minutes of scheduled time)
- Provide real time notice of delayed service visits and missed visits
• Use participant telephone number (provide justification if other than the land line)
• Not be the phone of a paid staff worker
• Use a toll-free number for calling in
• Generate bills using data recorded from the telephony system
• Are secure and HIPAA compliant
• Allow for alternate time verification arrangements when services are rendered outside
  the home

Agencies must have a protocol in place for making edits to electronic time sheets that includes
making contact with the participant and the worker.

Telephony time & attendance electronic records are accepted by the Commonwealth as
documentation of services rendered in support of claims for Medicaid reimbursement under
OLTL Waivers. Substantiation or backup of telephony time & attendance records with paper
timesheets is not required.

The following types of service providers may use telephony systems:

• Home Health Agency
• Home Care Agency
• Licensed Dietician
• Out-Patient Rehabilitation Agency/Behavioral Therapy Provider
• Service Coordination Agencies
• Visiting Nurses
• Personal Care Agencies

Telephony services can be used for the following waiver services under OLTL HCBS programs:

• Personal Assistance Services (including Personal Care, Home Support and Companion
  Services)
• Home Health
• Respite
• Therapeutic and Counseling Services
• Community Integration
• Service Coordination
• Participant-Directed Community Supports

**Community Transition Services**

Community Transition Services are one-time expenses for individuals who make the transition
from an institution to a qualified living arrangement. Funds may be used to pay expenses
necessary to enable an individual to establish and move into a basic living arrangement,
including, but not limited to: security deposits required to obtain a lease on an apartment or
house; specific set-up fees or deposits, e.g., utilities (water, heating, telephone); essential furnishings to establish a basic living arrangement (bed, dining table and chairs, eating utensils & food preparation items, and basic appliances, as necessary).

Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances that are intended for purely diversional / recreational purposes. Under no circumstances will Community Transition Service funds be used to pay for furnishings or set up living arrangements owned or leased by a OLTL Waiver provider.

Community Transition Services are needs-based and furnished only to the extent that (1) they are reasonable and necessary as determined through the service plan development process, and (2) the individual is unable to meet such expense or the service cannot be obtained from other sources. These goods and services must be pre-authorized by OLTL in the waiver participant’s individual support plan.

**Care Management Instrument (CMI)**

The enrolling agency or AAA completes the CMI in collaboration with the participant (or the participant’s representative / others at the participant’s request) when an individual applies for an OLTL Waiver Program, Act 150 or the Options program. The CMI is to be completed by CM/SC at the annual reevaluation or as individual service needs change. The CMI does not need to be completed every six (6) months unless the participant’s needs change.

**Section II. Aging Waiver**

**Mandatory Enrollment in the Aging Waiver**

This Bulletin immediately rescinds and replaces the provision previously contained within Chapter 3 of the HCBS Manual that allowed Area Agencies on Aging (AAAs) discretion to develop a service plan funded by the Options program not to exceed $200 per month for individuals who decline to participate in the Aging Waiver. This Bulletin clarifies that the Options program is only available for individuals who do not meet the financial eligibility criteria for a Waiver program and therefore cannot be used to substitute services in the manner previously described in Chapter 3 of the HCBS Manual.

If an individual is financially and clinically-eligible (per the Level of Care Assessment for OLTL waiver services, but declines enrollment in the Aging Waiver, a service plan cannot be funded with public resources via the Options program. An individual meeting this description may elect to receive Options services only if they agree to pay the full cost of the services, including the cost of care management.

Note that this requirement does not apply to the Family Caregiver Support program (FCSP) or services that do not require Care Management, such as transportation and home-delivered meals. An AAA may still authorize non-care managed services, such as FCSP, transportation or home-delivered meals, for individuals declining participation in the Aging Waiver(s).
Hearings & Appeals for Department of Aging and Office of Long-Term Living

To promote consistency among the HCBS programs and ensure that participants have timely access to a formal administrative hearing as required by federal rules, the Office of Long-Term Living hereby eliminates the informal resolution process for appeals brought by participants in the Aging Waiver. This clarification serves as notice that the OLTL hereby waives its regulations found at 6 Pa. Code Section 3.5 and the informal resolution process as described in Chapter 5 of the HCBS Manual, for Aging Waiver appeals.

AAAs will use the Notice of Adverse Action Form, as provided by OLTL. This Notice instructs participants to request an appeal by writing to the appropriate staff member at the AAA, rather than to the Secretary of Aging. For these types of appeals, the AAA will now be responsible for recording receipt of the appeal request and forwarding it to DPW’s Bureau of Hearings and Appeals (BHA) in a timely fashion. The Notice of Adverse Action Form, instructions for sending formal appeals to BHA and a template cover sheet will be distributed under separate cover.

Note that the Department of Aging will continue to handle other appeals (e.g., OAPSA alleged perpetrator designation, service provider appeals, Domiciliary Care certifications, and other state-funded services, including Options and Family Caregiver Support), through the informal resolution procedure outlined in our regulations.

AAAs should continue their attempts to resolve the issue underlying the appeal at the local level. However, this process must not delay the AAA’s submission of the participant’s hearing request to BHA. If attempts to resolve the issue are successful, the participant and AAA should notify BHA accordingly and request that the hearing be cancelled.

Locus of Care

Those questions in Section 6a of the Level of Care Assessment (LOCA) pertaining to care manager recommendations for the appropriate locus of care have been deleted from the assessment instrument.

Assessors / care managers should not make preemptive recommendations or determinations regarding appropriate care settings for prospective Aging Waiver participants. Decisions regarding service options or care settings require consultation with and informed consent by the waiver participant (or his/her designated representative) during the development of the care plan / individual support plan.
Participants who choose to employ personal assistance workers in one of OLTL’s participant-directed waiver programs will be required to have criminal history background checks performed on the workers they wish to hire. The participant will be informed of the results of the criminal history background check.

The Care Manager/Service Coordinator (CM/SC) should remind the participant-employer that if the CM / SC, Fiscal/Employer Agent (F/EA), Department of Aging, Department of Public Welfare, or other investigative or law enforcement agency determines that the participant-employer and/or personal assistance worker has submitted or caused to be submitted claims for Medical Assistance (Medicaid) payments (e.g., timesheets) which the participant-employer and/or personal assistance worker is not otherwise entitled to receive, the participant-employer and/or personal assistance worker may be prosecuted under Federal, State, and local laws. The F/EA should ensure that the criminal history background check is completed and that the Direct Care Worker (DCW) Agreement is signed and retained in the DCW file (see Attachment 3).

In cases of Medicaid fraud, the participant-employer cannot hire that personal assistance worker, per the following statutory prohibitions. Title 55 Pa. Code §1101.76(5) specifies that the person convicted of fraud is ineligible to participate in the MA program for 5 years from the date of conviction. Additionally, under 55 Pa. Code §1101.77(b)(3)(i), if the Department of Public Welfare has an additional basis for termination which is unrelated to, and in addition to, the criminal conviction, it may terminate the provider for a period in excess of 5 years. An application for re-enrollment cannot be made until the 5-year ban has expired.

The F/EA is responsible for securing a Pennsylvania State Police criminal history background check. In addition, a Federal Bureau of Investigation (FBI) check is required when a personal assistance worker has not lived in Pennsylvania for the previous two years.

Child Abuse Clearances
When there is a child living in the home where services are being provided, the F/EA is responsible for securing child abuse clearances for prospective personal assistance workers and must have a system in place to document that the child abuse clearance was conducted and obtained from the Office of Children, Youth and Families (OCYF), Childline and Abuse Registry, Department of Public Welfare within 30 work days from the date the worker initiates services to the participant. If a worker does not obtain – or fails – a child abuse clearance, the worker cannot be employed by the participant if there is a child living in the home where services will be provided.

In general, child abuse clearance results are mailed to the requestor within 14 days from the date that the clearance request is received by OCYF. In cases where the worker does not return the original clearance within the timeframe listed above, the F/EA should notify the participant-employer that his or her worker has not submitted the required child abuse clearance results. The F/EA should remind the participant-employer that child abuse clearances are required for all personal assistance workers providing services in homes where
children reside. The F/EA must inform the participant-employer that if the worker does not submit his or her original clearance within the required 30 work days, the employee cannot continue working. In those cases, the participant-employer may need to dismiss the worker.

**Criminal history background checks will be performed at no cost to the participant.** Performance of the criminal history background check and its cost will be the responsibility of the F/EA.

**Participant Selection of Criminal History Background Check Option**

☐ I have read the above policy and I understand that a criminal history background record check on all personal assistance workers is mandatory.

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Attachment 2

DEPARTMENT OF PUBLIC WELFARE
DEPARTMENT OF AGING
OFFICE OF LONG-TERM LIVING

DIRECT CARE WORKER AGREEMENT
Home and Community-Based Services

Agreement between the Office of Long-Term Living and the Direct Care Worker/Vendor

Direct Care Worker/Vendor: ________________________________________________________

Address: _______________________________________________________________________

Phone: ___________________________ Fax: ___________________________

The direct care worker (DCW) or direct service provider/vendor agrees to accept check(s) for
item(s) or service(s) purchased for individuals served through the Office of Long-Term Living’s
(OLTL) home- & community based waivers. Financial management for these services and
purchases is provided by ____________________, which is not the employer of the (DCW).
Acceptance and endorsement of the check(s) will signify that the DCW or direct service
provider/vendor agrees to the following terms and conditions:

1. Accept payment, in the form of check(s) or direct deposit, from ___________________________ doing business in the Commonwealth of Pennsylvania.
2. Agree to maintain records of the service(s) or purchase(s).
3. Provide only the service(s) or item(s) authorized on the check(s).
4. Accept the check(s) or direct deposit(s) as payment in full for service(s) or item(s)
purchased.
5. No additional charges will be made or accepted from participants.
6. Upon request, provide the OLTL or its designee information and documentation
regarding the service(s) or purchase(s) for which payment was made.

_____________________________________________________________________________
is signing this form as designated by the OLTL.

_____________________________________________________________________________
will maintain the original copy of this form in the applicable file as appropriate.

_____________________________________________________________________________
Fiscal/Employer Agent’s signature

_____________________________________________________________________________
Direct Care Worker or Vendor’s signature

_____________________________________________________________________________
Print Name

_____________________________________________________________________________
Print Name

Date: _______________

Note: Blank line in agreement is for the Name of Fiscal/Employer Agent
PURPOSE:
OLTL establishes the following protocol to ensure that service plan development is conducted in the best interests of the participant and to assure the participant was offered a choice between available waiver services alternatives and qualified waiver providers.

SCOPE:
This OLTL protocol is directed to Area Agencies on Aging (AAA) and providers of Service Coordination for the OLTL Waivers.

BACKGROUND:
The method by which choice of providers and services is offered to participants varies among the home- & community-based service programs. Consistent with standards set forth by the Centers for Medicare and Medicaid Services (CMS), in conjunction with OLTL efforts to standardize procedures for efficient access to home- & community-based services, the following procedure has been developed to strengthen safeguards and promote participant choice and preference.

DISCUSSION:
OLTL has developed a standard form for all home and community-based service programs. The form is called “Service Provider Choice Form”. All Care Managers/Service Coordinators (CM/SC) must present and explain the form to participants at the time of the Care Plan / Individual Service Plan (ISP) development and at each subsequent re-evaluation.

The Service Provider Choice Form will provide information to participants that they may receive both care planning / service coordination and choose waiver services from different providers or from the same provider, based on their preference. In addition, participants have the right to change providers at any time.

PROCEDURE:

Care Managers/Service Coordinators

1. Service Coordinators (SC) are responsible for providing participants with the link to the new Service and Supports Directory (SSD) at the time of the initial Service Plan development. The link is located at: https://www.humanservices.state.pa.us/compass.web/EPProviderSearch/Pgm/EPWEL.aspx?prg=LTH

The SSD allows individuals receiving OLTL services, family members, SC and the general public to access timely, up-to-date information on providers and services being offered in their area.

2. AAA Care Managers (CM) should use a randomized list of local providers generated by the AAA from the SAMS database. This listing can be generated by each AAA for its agency using the custom report provided for that purpose. This report is
automatically randomized by service and updated for any new providers or terminated providers. This report can be exported to a PDF, word, or excel file and either printed, distributed to appropriate staff members or positioned on the agency server for reference by all members. This report randomizes the provider list by service every time it is run or refreshed. AAAs may run the report periodically and use the results for a set period of time or run the report every time a provider is requested. If the agency elects to run the report periodically it must be updated at least monthly.

3. Service Coordination agencies must provide participants with a printed list of service providers from the SSD if the participant does not have access to a computer.

4. CM/SC’s are required to confirm in HCSIS (or SAMS for the Aging Waiver) that the participant has received, reviewed and signed the Service Provider Choice Form.

5. Documentation of the receipt of the form by the participant must be present in the participant’s ISP/Care Plan. The Service Provider Choice form must be reviewed and signed at the time of re-certification / re-determination or when a participant requests a change in service providers.

6. If there is a request to change providers, the CM/SC is responsible for reviewing the Service Provider Choice Form along with the list of service providers from the SSD or AAA provider list and obtaining the participants signature to document their request for a change in provider. Notation of a change in provider must be kept in the participant’s file and confirmed in the Notes section of HCSIS or (Journal section in SAMS for the Aging Waiver) to notify OLTL of a change in provider.

7. The CM/SC must present the list of service providers from the SSD or AAA provider list and assist the participant in making an informed choice. If a participant does not have a preference, the CM/SC must document that there was no preference after the information was reviewed with the participant and then proceed to make referrals to providers at the top of the randomly-generated list.

8. The content of the discussion with the participant must be documented in the participant’ ISP and in the Notes section of HCSIS or (Journal section of SAMS for the Aging Waiver) for review by OLTL.

NOTE: For the AIDS Waiver, the form must be submitted via hard copy (fax) to the OLTL.
COMMONWEALTH OF PENNSYLVANIA
OFFICE OF LONG-TERM LIVING
SERVICE PROVIDER CHOICE FORM

Name (Last, First, Middle):

Address: County:

Before you choose who will be providing your home- & community-based services, you need to be aware of your rights as a program participant:

1. You have the right to decide who will give you the services listed in your Individual Service Plan (ISP) as long as they are enrolled in the program and qualified to provide you those kinds of services.

2. You have the right to talk to or interview any provider before making your choice of providers. Interviewing providers can be a long process and might result in a delay of services.

3. You will not be forced to choose a particular provider.

4. You can decide on a different provider for each different service.

5. You may choose more than one service provider to give you the same type of service as outlined in your ISP.

6. Even though your service coordination agency may also be a provider of other services, you do not have to choose that agency to provide your other services.

7. If you receive services from the COMMCARE Waiver, your service coordination agency cannot be the provider of any other services.

8. You may self-direct your home- & community-based services if the particular waiver program in which you are enrolled permits this model, and you qualify for self-direction services.

9. You may choose to self-direct some of your services and receive others from a different provider, such as a homecare / home health agency.

10. You may change your mind about who provides your services at any time by telling your Service Coordinator (or Care Manager for the Aging Waiver).

11. If there are issues you have been unable to resolve or it is difficult to discuss them with your Care Manager or Service Coordinator, you may call the OLTL Quality Assurance Helpline at 1-800-757-5042. There is no charge for calling this number.
Please acknowledge the following statements by checking each box and signing at the bottom of the form:

☐ I understand my rights to choose my provider(s) and my responsibilities in making those choices.

☐ My Care Manager/Service Coordinator has given me a list of service providers who could possibly provide each service listed in my Individual Service Plan from the Service and Supports Directory (SSD) located at: https://www.humanservices.state.pa.us/compass.web/EPPProviderSearch/Pgm/EPWE L.aspx?prg=LTH or from a list of providers supplied by the AAA Care Manager.

☐ I understand that I may talk to any services provider before making my decision in selecting a provider.

☐ I have freely chosen the provider for each service listed in my Individual Service Plan on the back of this form.

☐ I understand that I may:
  - Choose to self-direct some of my services if the waiver in which I am enrolled permits this model and I qualify to self-direct; or
  - Choose not to self-direct any, all or some of my services

☐ I have made these choices without being pressured or forced.

☐ I have been involved in developing my Individual Service Plan.

☐ I understand if I have concerns or complaints about my services that I should contact my Care Manager/Service Coordinator.

_________________________________________________________  _________________________________
Participant’s Signature                              Date

_________________________________________________________  _________________________________
Representative’s Signature (as appropriate)                 Date

_________________________________________________________  _________________________________
Care Manager/Service Coordinator Signature             Date

If you have someone who is helping you with or providing support to you regarding this discussion, please ask that person to sign below to show that they have participated by helping you.

_________________________________________________________  _________________________________
Signature                                              Date
# SERVICE PROVIDER CHOICE FORM

**Name (Last, First, Middle):**

**Address:**

**County:**

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