Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Pennsylvania** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**
Consolidated Waiver

C. **Waiver Number:PA.0147**
Original Base Waiver Number: PA.0147.91.R4

D. **Amendment Number:PA.0147.R05.02**

E. **Proposed Effective Date:** *(mm/dd/yy)*

07/01/13

Approved Effective Date: 07/01/13
Approved Effective Date of Waiver being Amended: 07/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The Commonwealth of Pennsylvania, Office of Developmental Programs (ODP) is submitting an amendment to the Consolidated Waiver to increase reserved capacity for unanticipated emergencies due to the implementation of the Adult Protective Services Act. Appendix J estimates have also been revised to reflect 380 additional participants served through the Consolidated Waiver as a result of the Waiting List Initiative granted in the 2013-2014 enacted budget.

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A – Waiver Administration and Operation**	

☑ **Appendix B – Participant Access and Eligibility**	B-3-c
☐ **Appendix C – Participant Services**	
☐ **Appendix D – Participant Centered Service Planning and Delivery**	
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I – Financial Accountability**	
☑ **Appendix J – Cost-Neutrality Demonstration**	J-2-d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

  Specify:
  Increase reserved capacity for Unanticipated Emergencies in Year 2 from 20 to 50 to reflect the increase in individuals entering the Waiver that meet these criteria due to the implementation of the Adult Protective Services Act.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Pennsylvania** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Consolidated Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: PA.0147
Waiver Number:PA.0147.R05.02
Draft ID: PA.03.05.02

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/12
Approved Effective Date of Waiver being Amended: 07/01/12

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

- [ ] **Hospital**

  Select applicable level of care

  - ( ) **Hospital as defined in 42 CFR §440.10**

    If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

  - ( ) **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

- [ ] **Nursing Facility**

  Select applicable level of care

  - ( ) **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

    If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

  - ( ) **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

- [x] **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

  If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

  People with a diagnosis of mental retardation (now referred to as intellectual disability), as defined in the current ODP policy bulletin regarding individual eligibility for Medicaid Waiver services.

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- (•) **Not applicable**
- ( ) **Applicable**

  Check the applicable authority or authorities:

  - [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
  - [ ] **Waiver(s) authorized under §1915(b) of the Act.**

    Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

    Specify the §1915(b) authorities under which this program operates *(check each that applies):*

    - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
    - [ ] **§1915(b)(2) (central broker)**
    - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
    - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**

  - [ ] **A program operated under §1932(a) of the Act.**

    Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

  - [ ] **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Consolidated Waiver has been developed to emphasize deinstitutionalization, prevent or minimize institutionalization and provide an array of services and supports in community-integrated settings. The Consolidated Waiver is designed to support persons with intellectual disabilities to live more independently in their homes and communities and to provide a variety of services that promote community living, including participant directed service models and traditional agency-based service models.

The Department of Public Welfare (Department), as the State Medicaid agency, retains authority over the administration and implementation of the Consolidated Waiver. ODP, as part of the State Medicaid Agency, is responsible for the development and distribution of policies, procedures, and rules related to Waiver operations. Most services and supports funded under the Waiver are authorized by local Administrative Entities (AEs) pursuant to an AE Operating Agreement with ODP. There are some services, Supplemental Habilitation and Additional Individualized Staffing, that require prior authorization from ODP. An AE is a County Mental Health/Intellectual Disability (MH/ID) Program or a non-governmental entity with a signed agreement with ODP to perform operational and administrative functions delegated by ODP related to the approved Consolidated Waiver. The AE Operating Agreement establishes the roles and responsibilities of AEs with respect to functions delegated to them for program administration.

AEs may only delegate and purchase administrative functions in accordance with the AE Operating Agreement. When the AE delegates or purchases administrative functions, the AE shall continue to retain responsibility for compliance with the AE Operating Agreement. In addition, the AE is responsible to monitor delegated or purchased administrative functions to ensure compliance with applicable Departmental rules, Waiver requirements, written policies and procedures, state and federal laws, and the provisions of the AE Operating Agreement. Administrative payments for the purchased administrative functions shall be paid through the Department's allocation to the AE for administration of the Waiver.

AEs are responsible for ensuring that Individual Support Plans (ISPs) are completed accurately before authorizing the services and approving the ISPs. AEs utilize the results of needs assessments, the standardized web-based ISP format in the Home and Community Services Information System (HCSIS) and ISP guidelines to ensure accuracy of the ISPs. AEs are also responsible for ensuring that ISPs are approved and services are authorized prior to the participant's receipt of Waiver services; and that ISPs include the services and supports necessary to meet the assessed needs of participants. AEs are responsible for monitoring that ISPs are updated on at least an annual basis, and whenever necessary to reflect changes in the need of Waiver participants.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- [ ] **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as

required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:

The Office of Developmental Programs presented information regarding the changes being made in this amendment to the Medical Assistance Advisory Committee on February 27, 2014.

J. **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) 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). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Allen
First Name:	Leesa
Title:	Executive Medical Assistance Director
Agency:	Secretary of Public Welfare
Address:	Health and Welfare Building, 625 Forster Street
Address 2:	
City:	Harrisburg
State:	**Pennsylvania**
Zip:	17120
Phone:	(717) 787-2600 **Ext:** ☐ **TTY**
Fax:	(717) 787-6583
E-mail:	leallen@pa.gov

If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Mochon
First Name:	Julie
Title:	Policy Supervisor
Agency:	Office of Developmental Programs
Address:	Health and Welfare Building, 625 Forster Street
Address 2:	Harrisburg
City:	
State:	**Pennsylvania**
Zip:	17120
Phone:	(717) 783-5771 **Ext:** ☐ **TTY**
Fax:	(717) 787-6583
E-mail:	jmochon@pa.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:	Julie Mochon
	State Medicaid Director or Designee
Submission Date:	Jun 3, 2014

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:	Gordon
First Name:	Vincent
Title:	Deputy Secretary
Agency:	Department of Public Welfare, Office of Medical Assistance Programs
Address:	625 Forster Street, Health and Welfare Building
Address 2:	
City:	Harrisburg
State:	**Pennsylvania**

Zip: 17120

Phone: (717) 787-1870 **Ext:** ☐ **TTY**

Fax: (717) 787-4639

E-mail: vingordon@pa.gov

Attachments

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A, Quality Improvement Performance Measure Remediation Continuation:

Performance Measure a.i.6. Number and percent of final orders by the Department's Bureau of Hearings and Appeals implemented within 30 calendar days of the final order ruled in favor of the appellant.
ODP maintains a log of Fair Hearing requests for waiver participants. When a Fair Hearing request results in the Department's Bureau of Hearings and Appeals rendering a decision, that information is recorded in the log along with any required action. The AE must ensure that the final order is implemented within the expected timeframe. If the order is not implemented within the expected timeframe, the AE will be required to ensure remediation within five calendar days of notification by ODP. The AE will work with the SCO to revise the ISP if necessary or initiate/continue the service. The AE shall notify ODP of the remediation action that has occurred within 10 days.

Performance Measure a.i.7. Number and percent of AEs that qualify providers using qualification criteria as outlined in the current approved Waiver.
Through the AEOMP, ODP reviews a sample of provider initial and annual provider qualification applications. ODP ensures that each AE reviews provider qualification information using ODP standardized procedures. If the AE does not qualify a

provider using ODP standardized procedures, the AE is expected to contact the provider and collect all missing documents within 30 days. If the documentation obtained does not corroborate that the provider meets qualification standards, the provider will be prohibited from receiving payments for waiver services. ODP will provide training to the AE on the correct application of the provider qualification process. ODP will enhance its monitoring of the AE and if the problem persists, initiate sanctions as specified in the AE Operating Agreement.

Performance Measure a.i.8. Number and percent of AEs that monitor providers using the monitoring processes developed by ODP.
ODP identifies annually the providers to be monitored using the ODP standardized monitoring process and tool. Upon completion of monitoring for each provider, the AE will complete and submit the standardized monitoring tool to ODP. Through the AEOMP, ODP reviews a sample of providers monitored by each AE. If the AE does not complete provider monitoring using the monitoring processes developed by ODP, the AE will remediate identified deficiencies and notify ODP of the completion of remediation actions within 30 days.

For any of the above Administrative Authority Performance Measures, the Department will initiate actions as needed to resolve any outstanding issues with AE performance using the methodology outlined in the AE Operating Agreement.
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Appendix C, Quality Improvement Performance Measure Remediation Continuation:

Performance Measure a.i.b.2. Number and percent of current non-licensed, non-certified providers that meet Waiver requirements ongoing.
Current providers are expected to provide documentation to ODP or AEs indicating that they meet requirements at the required frequency. Each provider's specialty qualification expiration date is recorded and tracked electronically. Prior to a provider's qualification expiration date, the AE and the provider receive alerts notifying them of the provider's impending expiration. ODP or AEs are expected to notify the provider and ascertain whether there are impediments to providing qualification documentation by the qualification expiration date and provide assistance as needed. ODP sends an advance notice to the provider at least 30 days prior to their qualification expiration date informing them that failure to submit required qualification documentation by the expiration date will result in the provider becoming not qualified to provide the expired specialty and any expired specialty provided after the expiration date will be ineligible for reimbursement through the waiver. This notice will also inform providers that participants receiving the expiring specialty will start being transitioned to the participant's choice of willing and qualified providers and inform providers of their right to request a fair hearing through the Department. ODP and the responsible AE(s) will then begin activities to transition participants from providers who have expiring specialties to the participant's choice of willing and qualified providers. On the expiration date, should the provider fail to submit qualification documentation, ODP will not qualify the provider to provide the expired specialty. ODP will send a letter to the provider informing them that they are not qualified to provide the specialty under the Waiver, that any expired specialties provided after the expiration date are ineligible for reimbursement through the waiver and that they have the right to appeal as specified in 55 Pa. Code Chapter 41. Should the provider desire to provide the specialty through the Waiver in the future, they may reenroll for the specialty as long as they meet qualifications.

Performance Measure a.i.b.3. Number and percent of providers delivering services to participants who are self-directing that meet initial requirements.
ODP conducts a readiness review of the statewide Vendor Fiscal Employer Agent Financial Management Services to determine readiness to begin providing services. Issues identified during the review are addressed through ODP's standardized CAP process with remediation expected within 30 days.

Performance Measure a.i.b.4. Number and percent of providers delivering services to participants who are self-directing that meet ongoing requirements.
ODP conducts periodic reviews of provider performance with at least one review occurring every two years. ODP informs the provider of any noncompliance with terms of the contract or policies and procedures. If for example, provider records do not contain criminal background checks and/or child abuse clearances for prospective Support Service Workers (SSWs), the provider must locate and/or secure the documents. If the provider fails to locate or secure the required documentation, the employer is notified that the SSW can no longer provide waiver funded services and sanctions are applied as defined in the applicable contract or agreement.

Performance Measure a.i.c.1. Number and percent of licensed providers that meet training requirements in accordance with state requirements in the approved waiver.
ODP conducts annual onsite reviews of licensed providers. ODP notes any noncompliance areas, including a provider's failure to meet training requirements, and specific regulatory references on a Licensing Inspection Summary (LIS). The LIS is submitted to the provider who must return the document to ODP within 10 days of receipt specifying how noncompliance areas have been corrected or plan to be corrected. Providers must also send supporting documentation to ODP to verify that the correction has been made. Repeat noncompliance may affect the provider's certificate of compliance status. If the LIS is

not received within 10 working days, ODP will not issue to the provider a regular or provisional certificate of compliance and will initiate additional sanctions.

Performance Measure a.i.c.2. Number and percent of non-licensed providers that meet training requirements in accordance with state requirements in the approved Waiver.
Through the Provider Monitoring process, ODP or AEs conduct onsite reviews of 100% of providers on a one-year cycle for SCOs and a two-year cycle for all other providers using the standardized monitoring tools developed by ODP. ODP reviews the training records for all Supports Coordinators and Supports Coordinator Supervisors with a waiver caseload to determine that they attended and completed all required trainings. The AE reviews the training records of the 10 most recently hired staff members who were hired on or before August 1st or all records of staff hired within the prior 12 months (in cases where less than 10 staff were hired). If the required staff training is not documented in the record, ODP or the AE will notify the provider and the provider must locate missing documentation or ensure that training is provided within 30 days. The remediation for this process will occur as outlined in the ODP-established corrective action process.
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Appendix D, Quality Improvement Performance Measure Remediation Continuation

Performance Measure a.i.b.1. Number and percent of ISPs that are developed consistent with state policies and procedures as described in the Waiver.
Through the AEOMP, ODP reviews a sample of records to determine if ISPs are developed consistent with the State policies/procedures and ISP Bulletin. ODP will determine if specific criteria have been included in the ISP with remediation expected by the AE when deficiencies in the record are noted:

•Annual ISP meeting attendance: If any participant required to attend the ISP elects not to attend the ISP meeting, the reason should be documented on the ISP Signature Page. If documentation was not present to explain the absence of a required team member, remediation is required. If the participant did not attend the meeting, the AE must provide evidence to ODP that the Supports Coordinator reviewed the results of the ISP meeting with the participant, completed the ISP Signature Page, noting the date and that the review was done outside of an ISP team meeting. If the waiver provider did not attend the meeting and the reason for their absence is not documented on the ISP Signature Page, then the SCO will communicate with the provider to verify receipt of the invitation letter. The SCO will communicate ODP's expectation regarding provider attendance at ISP meetings. Confirmation may consist of, but is not limited to: email correspondence, formal letter or file/service note in the participant's record. Remediation is expected within 30 days.

•ISP content is consistent with ODP requirements: If documentation in the ISP does not meet ODP's content requirements, the AE will work with the SCO to ensure the ISP is amended to include language specific to the identified area of noncompliance. Within 21 days, the AE will work with the SCO to provide ODP with the ISP approval date that reflects the changes made to the ISP correcting the identified noncompliance. Retraining of staff in the AE who review and approve ISPs will be provided as needed.

•The AE authorizes services consistent with service definitions: If insufficient documentation is found in the approved ISP to support authorization of a service by the AE, the AE will work with the SCO to ensure the ISP is amended to include language specific to the identified area of noncompliance. If a service was authorized inconsistent with the service definition, due process notice will be issued to the participant that the service will be reduced or terminated. Retraining of staff in the AE who review and approve ISPs will be provided as needed. Remediation is expected within 21 days of notification.

•The AE authorizes qualified provider (s) to deliver all services in the approved ISP. If noncompliance was related to missing or incomplete documentation of a provider's qualified status in the system, the AE can submit documentation that demonstrates the provider was qualified at the time of service authorization. The AE may also provide documentation that the provider is currently qualified to render services. ODP will recoup any waiver funds that were paid to a provider that was not qualified at the time services were delivered. The AE will ensure that the ISP team identifies a willing and qualified provider to render the needed waiver service. Retraining of staff in the AE who review and approve ISPs and authorize services will be provided as needed. Remediation by the AE is expected within 30 days.

Performance Measure a.i.c.1. Number and percent of waiver participants whose Annual ISPs were reviewed and/or revised and approved within 365 days of the prior Annual ISP.
Through the AEOMP, ODP reviews a sample of records that identify any participants for whom Annual ISPs are not approved within 365 days of the prior Annual ISP. If there is no evidence in the record that the ISP was completed, approved, and services authorized by the Annual Review Update Date, the AE will work with the SCO to ensure the ISP is completed within 30 days of notification.

Performance Measure a.i.c.2. Number and percent of waiver participants whose needs changed and whose ISPs were reviewed/revised accordingly.

Through the AEOMP, ODP reviews a sample of records to determine if ISPs were revised when a change in need was identified that required a waiver service revision. If the ISP is not revised, then the AE will work with the SCO to ensure that correct revisions to the ISP are made. Remediation is expected to occur within 21 days of notification.

Performance Measure a.i.d.1. Number and percent of ISPs in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the ISP.
Using the sample of waiver participants drawn through the AEOMP, ODP reviews monitoring conducted by the participant's Supports Coordinator. The ODP standardized individual monitoring tool includes questions evaluating whether services are delivered as specified in the ISP. The tool is completed in HCSIS. In any instance where the Supports Coordinator identifies a concern regarding service delivery, and the issue remains unresolved, the AE will work with the SCO to resolve the situation. Resolution can include but is not limited to changes in service provider, resumption of services at required frequency, team meetings, or changes in service schedule. The AE will provide documentation of the resolution to ODP. Remediation is expected to occur within 21 days of notification.

Performance Measure a.i.e.1. Number and percent of new enrollees who are afforded choice between Waiver services and institutional care.
On a monthly basis, ODP generates and distributes to the specific AE, HCSIS reports including a list of exceptions for that AE (any individual for whom Service Delivery Preference is not entered into HCSIS as required prior to the Waiver start date). The AE is responsible to review these reports and provide remediation for any situation where Service Delivery Preference has not been completed and/or the date has not been recorded prior to Waiver enrollment. Remediation will include completion of Service Delivery Preference documents and/or data entry into HCSIS. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

Performance Measures a.i.e.2 and a.i.e.3. Number and percent of waiver participants whose records document choice between and among services was offered to the participant/family and Number and percent of waiver participants whose records document choice between and among providers was offered to the participant/family.
Through the AEOMP, ODP reviews a sample of records to determine if participants/families have been offered choice between and among services and providers. If there was no documentation that choice between and among services and providers was offered, the AE will work with the SCO to locate or complete the documentation on the ISP Signature Page. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

Performance Measure a.i.e.4. Number and percent of new waiver enrollees and waiver participants who are provided information on participant directed services.
Through the AEOMP, ODP reviews a sample of records to determine if new waiver enrollees and waiver participants are provided information on participant directed services. If there is no documentation on the ISP Signature Page that information on participant directed services was provided, the AE will work with the SCO to review the option with the person, complete and date the portion of the ISP Signature Page regarding participant directed services and indicate on the form that the option of participant directed services was reviewed with the waiver participant outside of an ISP team meeting. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

For any of the above Service Plans Performance Measures, the Department will initiate actions as needed to resolve any outstanding issues with AE performance using the methodology outlined in the AE Operating Agreement.
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APPENDIX G.2.a.i - RESPONSE CONTINUATION
DETAILED DOCUMENTATION REGARDING THE USE OF RESTRAINTS

Regulations also specify the content of the restrictive procedure plan. It must address:
• The specific behavior addressed;
• Antecedent or reason for behavior;
• Measurable desired outcome;
• Behavior modification methods;
• Alternatives to restrictive behaviors; and,
• What type of procedure, under what circumstances its applied and how.

If a restraint is used in a licensed setting, the restraint application will be reviewed by a restrictive procedure review committee that is convened by the provider. The restrictive procedure review committee contains a majority of persons who do not provide direct services to the participant and is responsible to establish a time frame for review and revision of the restrictive procedure plan, not to exceed 6 months between reviews. Recommendations from the committee must be incorporated or responded to prior to approval of the restrictive procedure plan being approved for implementation.

During licensing surveys, if there has been a restraint requiring the development of a plan, that plan must be evaluated to ensure review and approval by the chairman of the restrictive procedure review committee and by the provider program specialist prior to the use of restraint.

According to ODP policy, a participant's physical condition must be evaluated throughout the restraint in order to minimize the potential of individual harm or injury. Manual (physical) restraints cannot exceed 30 minutes within a two-hour time period. A participant is immediately released from physical restraint when they no longer present a danger to self or others. Support staff monitor the participant for signs of distress throughout the restraint process and for a period of time (up to two hours) following the application of a restraint.

The restrictive procedure plan includes the specific behavior to be addressed, the suspected antecedent or reason for the behavior, the single behavioral outcome desired stated in measurable terms, and a target date for achieving the outcome. The restrictive procedure plan must also include methods for modifying or eliminating the behavior, such as changes in the participant's physical and social environment, changes in the participant's routine, improving communication, teaching skills and reinforcing appropriate behavior. It must also contain the types of restrictive procedures that may be used and the circumstances under which the procedure may be used, the amount of time the restrictive procedure may be applied and the physical problems that require special attention during the use of the restrictive procedure. According to ODP policy, all licensed providers must have written restraint policies. Department annual licensing inspections review compliance with the following requirements:
• A restrictive procedure plan must be developed and approved prior to the use of any restraint.
• A restrictive procedure plan must be developed to ensure the health and safety of a participant when two or more emergency restraints are employed within 6 months.
• The restrictive procedure plan, and revisions, must be documented in the ISP.
• The only exception to using a restraint without a restraint procedure plan is when the restraint is used in an emergency to protect the health and safety of a participant.
• Copies of the restrictive procedure plan are kept in the participant's record.
• Meeting records of the restrictive procedure committee are also required kept on file.
• Each restraint is reported/documented in HCSIS.
• Documentation of the training program must include: -Names of staff trained; -Dates trained; -Training description; and -Source of training.

EDUCATION AND TRAINING REQUIREMENTS FOR PERSONNEL WHO ADMINISTER RESTRAINTS
Regulations require provider staff that administer restraints to have specific training regarding the appropriate use and safe implementation of restraints, as well as de-escalation techniques/alternatives to restraints. This training must be completed within the past 12 months and focus on the proper procedures and specific techniques to follow, ethics of using restraints and alternative positive approaches.

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Appendix G Quality Improvement Performance Measure Remediation Continuation:

Performance Measure a.i.11. Number and percent of deaths of waiver participants examined according to state protocols.
When ODP discovers that a waiver participant whose death occurred in a residential setting was not examined according to the state's protocol, ODP follows up with the appropriate entity to ensure the required protocol is carried out within 24 hours and a Corrective Action Plan is developed and implemented to prevent recurrence.

Performance Measure a.i.12. Number and percent of incidents of restraint where proper procedures were followed, by type of restraint.
ODP regulations specify that any waiver participant who has two emergency restraints within a six month period must have a behavior support plan with a restrictive procedure plan. When ODP discovers that proper procedures were not followed, a behavior support plan with a restrictive procedure plan that meets ODP regulations must be developed, approved and implemented within 30 days.

Performance Measure a.i.13. Number and percent of medication errors, by type.
This performance measure is designed to support evaluation of trends and patterns in the occurrence of medication errors. The number and percent of medication errors is reviewed to identify opportunities for systemic improvement as described in Appendix H.

Performance Measure a.i.14. Number and percent of complaints, by type.
This performance measure is designed to support evaluation of trends and patterns in the occurrence ofcomplaints. The number and percent of complaints is reviewed to identify opportunities for systemic improvement as described in Appendix

H.

Performance Measure a.i.15. Number and percent of complaints resolved within 21 days of receipt.
When a complaint is received through ODP's Customer Service system, the complainant is contacted within 24 hours and corrective action is planned in conjunction with the AE or provider if warranted. Corrective action must occur or be planned within 21 days unless there is an imminent health and safety risk, in which case corrective action is taken immediately. If corrective action is not carried out by the AE or provider as planned, then ODP staff will contact the appropriate entity to ensure that corrective action is undertaken or planned within 72 hours. If corrective action is not taken or planned, sanctions may be applied. The ODP Customer Service Lead reviews the data on a monthly basis to ensure that corrective action is timely and clearly documented.

Performance Measure a.i.16. Number and percent of licensed providers that ensure waiver participants receive physical exams in accordance with ODP rules.
ODP conducts annual onsite reviews of licensed providers. ODP notes any noncompliance areas, including a provider's failure to meet the requirement for waiver participants to receive annual physical examinations, and specific regulatory references on a Licensing Inspection Summary (LIS). The LIS is submitted to the provider who must return the document to ODP within 10 days of receipt specifying how noncompliance areas have been corrected or plan to be corrected. Providers must also send supporting documentation to ODP to verify that the correction has been made. This supporting documentation must be received within 30 but no more than 90 days of the date of discovery. Repeat noncompliance may affect the provider's certificate of compliance status. If the LIS in not received within 10 working days, ODP will make contact with the provider to resolve the issue. If determined to be warranted, the licensing administrator will not issue a regular or provisional certificate of compliance and will initiate additional sanctions.
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Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ◉ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
   Pennsylvania Office of Developmental Programs (ODP)
   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this

policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

   The Deputy Secretary of the Office of Developmental Programs (ODP) reports directly to the Secretary of Public Welfare. The Secretary of Public Welfare is the head of the single state Medicaid agency. ODP functions as part of the Department of Public Welfare (Department). The Secretary of Public Welfare, the State Medicaid Director (Deputy of the Office of Medical Assistance Programs) and the Deputy Secretary of the Office of Developmental Programs meet regularly to discuss operations of the Waivers and other long term living programs. Therefore, the State Medicaid Agency through the Secretary of Public Welfare has ultimate authority over operations of the Waiver. The roles and responsibilities of the operating divisions within the Department, including ODP and OMAP, are outlined on the following Department of Public Welfare website http://www.dpw.state.pa.us/dpworganization/index.htm.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   ODP retains the authority over the administration of the Consolidated Waiver, including the development of Waiver related policies, rules, and regulations. ODP only delegates specific functions to Administrative Entities (AEs) to ensure strong quality oversight of the Waiver program.

   Regulations, Waiver policies, rules and guidelines are distributed by ODP through Bulletins and other communications issued electronically. ODP retains authority for all administrative decisions and supervision of AEs, as well as the organizations the AE contracts with. Functions that the AE are permitted by ODP to delegate to or purchase from other organizations are specified in the AE Operating Agreement and are reported to ODP annually or when the AE initially delegates or purchases a function. The AE must also provide ODP with the monitoring protocol used to ensure that the functions are performed in accordance with all applicable requirements.

   ODP delegates the following responsibilities to AEs through the current AE Operating Agreement and applicable regulations and policies:

   •Monitoring of delegated or purchased administrative functions pursuant to a signed contract or agreement.

•Maintaining, safeguarding, and providing access to Waiver records.

•Monitoring to ensure individuals being identified for enrollment into the Waiver are assigned a category of need for services in accordance with the Department's policy and form (Prioritization of Urgency of Need for Services [PUNS] Form).

•Ensuring that individuals being identified for enrollment into the Waiver having an emergency need receive preference in Waiver enrollment before those having a critical or planning need.

•Ensuring fair hearing and appeal rights are explained to new waiver enrollees.

•Providing written notice to waiver participants when the AE makes determinations to deny, suspend, terminate or reduce a Waiver service or Waiver service request in accordance with the needs assessment and/or the approved Waiver.

•Implementing Departmental decisions, e.g., Bureau of Hearing and Appeals decisions.

•Evaluation and reevaluation of level of care as specified in the approved Waiver.

•Providing individuals being identified for enrollment into the Waiver who are likely to be determined eligible for an Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/ID) level of care, with choice between home and community based and institutional services (Service Delivery Preference).

•Qualifying Waiver providers using the qualification criteria outlined in the current approved Waiver, with the exception of qualification for Supports Coordination Organizations (SCOs).

•Monitoring of waiver providers, excluding SCOs, using a standard tool and process developed by ODP.

•Ensuring that information on participant direction is provided to new waiver enrollees.

•Reviewing and approving Individual Support Plans (ISPs) in accordance with ODP policies and procedures and making authorization determinations about Waiver-funded services using criteria established by ODP.

•Conducting Incident Management activities in accordance with ODP standards.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☑ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

ODP retains the authority over the administration of the Consolidated Waiver, including the development of Waiver related policies, rules, and regulations and has refined the list of delegated functions to ensure quality oversight of the Waiver program (see Appendix A.3). Regulations, Waiver policies, rules and guidelines are distributed by ODP through Bulletins and other communications issued electronically. ODP also retains the authority for all administrative decisions and the supervision of non-state public agencies

that conduct Waiver operational and administrative functions. ODP delegates functions to AEs through the AE Operating Agreement. The AE implements these responsibilities and meets the requirements specified in the approved AE Operating Agreement. See Appendix A-3 for a detailed list of responsibilities.

ODP currently utilizes AEs that are associated with a County MH/ID Program, unless the County MH/ID Program has expressed that it is unwilling or unable to perform Waiver operational and administrative functions as per the AE Operating Agreement.

☑ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

ODP retains the authority over the administration of the Consolidated Waiver, including the development of Waiver related policies, rules, and regulations. Regulations, Waiver policies, rules and guidelines are distributed by ODP through Bulletins and other communications issued electronically. ODP also retains the authority for all administrative decisions and the supervision of non-governmental, non-state entities that conduct Waiver operational and administrative functions.

ODP will utilize AEs to perform Waiver operational and administrative functions per the AE Operating Agreement.

ODP delegates functions to the AE through the AE Operating Agreement. The AE implements these responsibilities and meets the requirements specified in the approved AE Operating Agreement. See Appendix A-3 for a detailed list of responsibilities.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

ODP remains the ultimate authority for Waiver policies, rules, and regulations; and retains the ultimate authority on all administrative decisions. ODP retains the responsibility for supervision and assessment of the performance of AEs, and other contracted entities. ODP provides information and technical assistance to AEs through ODP Academy Training sessions, targeted technical assistance, and upon request.

ODP has oversight of the functions delegated to the AE through the Administrative Entity Oversight Monitoring Process (AEOMP).

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

ODP oversees the performance of the AEs through a variety of mechanisms including Incident Management (IM), Risk Management (RM), oversight monitoring, prior authorization of ISPs that include certain services, Service Reviews and the review of complaints.

The AEOMP is a standardized process designed to collect, compile and analyze data to monitor that the functions delegated to AEs are being performed in compliance with all ODP requirements including Waiver assurances and the AE Operating Agreement. The process includes a review of a sample of participant records. Compliance is reviewed in the following areas: Delegated functions in addition to those noted explicitly below; eligibility/level of care; due

process; ISP-timeliness, content and use of the ODP issued ISP Signature Page; provider qualifications and monitoring.

ODP is responsible for conducting the AEOMP. ODP guidelines are utilized to promote consistency in the use of the standardized monitoring tool. The review results are entered into a database by reviewers with any required remediation so that individual instances of noncompliance are tracked and performance data can be aggregated and analyzed.

A letter is sent to each AE reflecting their performance on all items measured. A Corrective Action Plan (CAP) is required for any AE that exhibits noncompliance in any area. ODP reviews and approves or disapproves the CAP. The AE is expected to implement the approved CAP. ODP validates that corrective actions are taken to remediate each instance of noncompliance within a prescribed timeframe and that other necessary actions are taken to avoid a recurrence.

AEOMP is implemented on a staggered basis, with a formal onsite review of each AE annually. A proportionate random sample is used to generate a representative sample for the Waiver and provides for the selection of participants from each AE at the same percentage as the AE represents in the Waiver population. A margin of error of 5%, confidence level of 95% and a response distribution of 70% is used.

ODP requires the AE conduct an Annual Administrative Review every year, using the standardized AE oversight monitoring tool. The AE must establish a review period/cycle each year for their administrative review. The AE must submit a written report of the AE Annual Administrative Review to ODP. ODP provides additional training and technical assistance to support the AE in the completion of the Annual Administrative Review.

As part of a larger RM program, ODP has had a standardized IM process since 2001 that includes safeguards to protect participants from situations that place them at risk. The primary goal of the IM process is to ensure the safety of participants and that when an incident occurs; appropriate actions are taken immediately to protect the participant from harm. ODP, AEs, SCOs and providers are required to report, investigate, initiate and/or monitor corrective action and follow-up activities. This process is described in greater detail in Appendix G.

Each of the four ODP regional offices has a RM workgroup that meets at least monthly to review and analyze regional incident and investigation data reported in HCSIS, provide feedback to the AEs and providers around RM/IM issues, develop regional improvement plans for RM/IM priorities, coordinate RM/IM training, and assess and track the outcomes of target objectives. Regional RM workgroups are used to promote the health and safety of participants by reducing the frequency and severity of adverse events through risk identification, evaluation, planning and implementation. RM meetings involve the review of regional data, including primary and secondary incident categories, problem prone and high risk incidents and certified investigations.

Regional RM forums are led by the ODP regional risk manager and consist of AE RM staff. The forums are held at least quarterly. The forums are used to foster collaboration with ODP regarding the identification and implementation of regional priorities emerging from the review of regional data by the RM workgroup. The forum members: review and analyze incident and investigation data, identify potential improvement strategies for implementation at the AE level, recommend regional and county RM/IM improvement priorities, monitor local incident levels identified for improvement, assure alignment of efforts to manage risk within AEs, assess and track outcomes of target objectives and modify target objectives and established priorities as needed. The information shared during the forums is reported at regional RM meetings and on a statewide basis.

ODP conducts Service Reviews of fair hearing requests in accordance with ODP policy for participants who have had waiver services denied, reduced, suspended or terminated by AEs. Service Reviews are used to ensure that AEs perform assigned administrative and operational functions in accordance with Waiver requirements. ODP sends Service Review findings to the AE, the participant/family, and the SCO and monitors implementation of the Service Review findings. Upon receipt of ODP's findings, the participant/family may continue the fair hearing process or withdraw their hearing request.

ISPs are reviewed by ODP during the Service Review process, the AEOMP and when services require prior authorization by ODP. ODP reports their decisions regarding prior authorizations to AEs, SCOs, participants and providers. ODP also reports any other issues identified in the ISP during the review to the AEs, SCOs and providers for resolution.

In order to ensure consistent prioritization of need and that all individual needs are met, ODP has a process designed to gather information to categorize the urgency of the needs of individuals who have requested services (PUNS process). ODP requires review of the PUNS form at least annually, and an update to the form as indicated. PUNS

forms are completed for all individuals who meet at least one of the following criteria: they are currently waiting for new or enhanced services; they have a projected need for service within the next five years; or they have a change in need to current services and supports. The ODP Regional Waiver Capacity Managers verify that any new individuals identified for enrollment or who are in the process of enrolling in the Waiver are in an emergency status. Verification is completed through a review of PUNS status in HCSIS. If no PUNS exists, or the PUNS status is anything other than Emergency, the Regional Waiver Capacity Manager contacts the AE to confirm that the individual is in an emergency status and the PUNS form needs to be completed or updated.

With the exception of SCOs, which are monitored directly by ODP on an annual basis, provider monitoring is conducted using standard tools and data collection documents to verify that providers are qualified and services are provided in compliance with the Waiver, federal and state requirements and the ODP Waiver Provider Agreement and OMAP Provider Agreement. All providers, excluding SCOs, self-report to the AE and ODP annually and have an onsite review conducted by the AE every two years.

Half of the Waiver providers are selected for an onsite review each fiscal year. The purpose of the onsite review is to validate the provider's self-report and is thus referred to as an audit. (Please note that this audit is not the same as the financial audit requirements identified in Appendix I.) Providers that are not audited in year one will be audited in year two. New providers that begin to provide waiver services before July 1st will be included in an onsite review during the fiscal year. New providers that begin to provide services after June 30th will be included in the onsite audits the following fiscal year. New providers also complete an abbreviated provider monitoring tool and submit it to the AE prior to being authorized to render services to ensure that new providers are oriented to program and Waiver requirements.

There are three phases of provider monitoring. Phase 1 is an ongoing activity throughout the year. In phase 1, the Performance Review phase, reports will be available quarterly to providers in HCSIS. These reports are reviewed by the provider to identify areas where they are performing to the standards and those areas where they may need to focus efforts for remediation and improvement. These reports will also be reviewed by ODP and AEs. ODP or the AE ensure that the provider performs remediation when there are areas identified for improvement or areas of noncompliance. The AE ensures that the provider remediates any identified areas of noncompliance.

In phase 2, the Self-Reporting Phase, providers use standardized monitoring tools to self-assess their compliance across a variety of measures derived from the Waiver requirements, ODP Waiver Provider Agreement, OMAP Provider Agreement, and ODP written policies and procedures. This information allows providers to plan their remediation and improvement strategies to enhance the quality of services and prepare for their On-site Audit. The data gathered from this phase also provides ODP with a baseline to track and trend statewide compliance of providers across measures. Providers complete the self-report annually.

Phase 3 is the On-site Audit phase conducted by the AE to validate the self-reported information submitted by the provider. The AE uses the same tool in the On-site Audit that was used by the provider in the Self-Reporting Phase.

For those providers subject to the On-site Audit, the Lead AE will contact the provider to schedule and conduct the On-site Audit, complete the Final Audit reports and conduct an Exit Conference (when requested or appropriate) with the provider to review their findings. Based on the findings of the Final Audit report and optional Exit Conference, the provider will develop and the AE will approve a CAP addressing any identified areas of concern.

A Lead AE is designated by ODP when a provider renders services in multiple counties/AEs. The Lead AE is the AE with which the most individuals served by the provider are registered. In the event the provider is a multi-county provider, the Lead AE communicates with the reviewing AEs (the AEs responsible for the participant(s) in the sample selected by ODP) in addition to the provider.

ODP receives complaints and concerns through a toll-free Customer Service Number. Each call follows an established protocol, including referral to the appropriate ODP Regional Office or Bureau, and timely follow-up. ODP staff review each assigned call and follow-up through a variety of methods based on the information provided, including initiating an investigation, conducting an on-site unannounced inspection and referral to an AE for review and action. Complaints are also reviewed by ODP Regional RM committees.

In accordance with ODP policy, additional information is obtained through Independent Monitoring for Quality (IM4Q), a statewide method that PA utilizes to independently review quality of life issues. This process includes a sample of participants. IM4Q monitors satisfaction and outcomes of participants through indicators organized into areas such as satisfaction, dignity and respect, choice and control, inclusion, and physical setting. Interview results are entered into HCSIS. IM4Q data is aggregated into provider, AE, regional and statewide reports. Aggregate data is used for continuous quality improvement purposes by ODP, AE and providers.

ODP uses information from the monitoring and oversight activities described above to identify areas in need of clarification or improvement. ODP also provides information and technical assistance to AEs through ODP Academy Training sessions and targeted technical assistance as necessary.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☑	☑
Waiver enrollment managed against approved limits	☑	☐	☐
Waiver expenditures managed against approved levels	☑	☐	☐
Level of care evaluation	☑	☑	☑
Review of Participant service plans	☑	☑	☑
Prior authorization of waiver services	☑	☐	☐
Utilization management	☑	☐	☐
Qualified provider enrollment	☑	☑	☑
Execution of Medicaid provider agreements	☑	☐	☐
Establishment of a statewide rate methodology	☑	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
   i. **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver

- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.1 Number and percent of AEs that implement monitoring protocols using the ODP standardized monitoring tool. Percent = number of AEs that implement monitoring protocols using the ODP standardized monitoring tool/number of AEs that delegate or purchase administrative functions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.2 Number and percent of AEs that maintain, safeguard, and provide access to waiver records as per ODP's expectations. Percent = number of AEs that maintain, safeguard, and provide access to waiver records as per ODP's expectations/number of AEs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.3 Number and percent of waiver participants whose category of need for services is reviewed/updated in accordance with the Department's policy and form (currently PUNS). Percent = number of waiver participants whose category of need for services is reviewed/updated in accordance with the Department's policy and form (currently PUNS)/number of waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.4 Number and percent of eligible applicants having an emergency need (the individual has current needs or anticipated needs within the next six months) who receive preference in waiver enrollment. Percent = number of eligible applicants having an emergency need who receive preference in waiver enrollment/number of eligible applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Capacity Management Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.5 Number and percent of waiver participants issued fair hearing and appeal rights in accordance with policies and procedures. Percent = number of waiver participants issued fair hearing and appeal rights in accordance with policies and procedures/number of waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation	**Frequency of data collection/generation**	**Sampling Approach***(check each that applies):*

(check each that applies):	*(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

a.i.6 Number and percent of final orders issued by the Bureau of Hearings and Appeals (BHA) ruled in favor of the appellant and implemented within 30 calendar days of the final order. Percent = number of final orders issued by BHA ruled in favor of the appellant and implemented within 30 calendar days of the final order/number of final orders issued by BHA ruled in favor of the appellant.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.7 Number and percent of AEs that qualify providers using qualification criteria as outlined in the current approved waiver. Percent = number of AEs that qualify providers using qualification criteria as outlined in the current approved waiver/number of AEs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.8 Number and percent of AEs that monitor providers using the standard tool and monitoring processes developed by ODP. Percent = number of AEs that monitor providers using the monitoring processes developed by ODP/number of AEs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation	**Frequency of data aggregation and**

and analysis *(check each that applies):*	**analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
For Performance Measures a.i.1, a.i.2., a.i.7., and a.i.8, as described in Appendix A-6, ODP staff use the AEOM tool and methodology to review the performance of all Administrative Entities.

For Performance Measures a.i.3, and a.i.5., as described in Appendix A-6, ODP staff use the AEOM tool and methodology to review a proportionate, representative random sample of waiver participant records annually.

For Performance Measure a.i.4, ODP staff use source data from HCSIS to inform Waiver Capacity Management Reports.

For Performance Measure a.i.6., ODP staff enters data into an Access database on the findings of reviews by the Bureau of Hearings and Appeals and implementation of final orders.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Performance Measure a.i.1. Number and percent of AEs that implement monitoring protocols using the standardized ODP monitoring tool. ODP receives from each AE annually a list of administrative functions that are delegated or purchased by that AE along with a copy of the monitoring protocol for each delegated or purchased function. On an annual basis, ODP reviews the list of each AE's delegated or purchased functions to verify implementation of the monitoring protocol. If ODP determines that an AE is not conducting monitoring activities as indicated in the protocol, the AE will be notified and is expected to complete remediation within 30 days. Remediation activities may include the AE locating missing evidence that documents their implementation of the monitoring protocol and/or the AE implementing required monitoring protocols and providing ODP supporting evidence. Evidence may include but is not limited to: correspondence with the responsible entity containing findings of monitoring; records of on-site visits to responsible entities; and corrective actions taken by responsible entities.

Performance Measure a.i.2. Number and percent of AEs that maintain, safeguard, and provide access to waiver records as per ODP's expectations.
Through the AEOMP, ODP evaluates whether AEs maintain, safeguard, and provide access to waiver records according to ODP's policies and procedures. If the AE does not maintain, safeguard, and provide access to waiver records according to ODP's policies and procedures, the AE is expected to document remediation actions and submit the documentation to ODP within 30 days. Remediation activities may include locating missing evidence of record retention, establishing secure record storage, and training staff on procedures to safeguard access and confidentiality of records.

Performance Measure a.i.3. Number and percent of waiver participants whose category of need for services is reviewed/updated in accordance with the Department's policy and form (PUNS).
On a monthly basis, ODP generates and makes available to AEs reports that identify any individual for whom a category of need for services form (PUNS) has not been completed in a timely manner. The AE is responsible to review these reports and work with the applicable SCOs to ensure remediation for any situation where a category of need for services form has not been completed/updated within 365 days. Remediation is expected to occur within 30 days and will include completion of category of need for service forms and entry of the information into HCSIS. AEs will summarize the remediation actions taken and provide the information to ODP staff.

Performance Measure a.i.4. Number and percent of eligible applicants having an emergency need who receive preference in waiver enrollment.
ODP reviews on a bi-weekly basis reports for individuals added to Intent to Enroll status (individuals who are in the process of being enrolled in the Waiver) to ensure that eligible applicants having an emergency need for services receive preference in waiver enrollment. For any individual who does not have emergency status on the waiting list, ODP reviews the record and/or contacts the AE to determine if the eligible applicant meets emergency criteria. The AE is instructed to update the record as necessary and appropriate. If ODP determines that the individual does not meet emergency status criteria, ODP will provide technical assistance/training to the AE regarding ODP's waiver enrollment policies. An AE that continues to fail to make the required corrections or updates to the record or to violate waiver enrollment policies will be suspended from making waiver enrollment decisions for a period of 90 days unless otherwise sanctioned by ODP. All requests for enrollment during the suspension period will be processed through an ODP Regional Office.

Performance Measure a.i.5. Number and percent of waiver participants issued fair hearing and appeal rights in accordance with policies and procedures.
Through the AEOMP, ODP determines if waiver participants in the sample were issued rights to fair hearing and appeals when the participant was determined likely to require ICF/ID level of care (for participants enrolled within the last twelve months) at the last annual ISP meeting, and at the time of a Service Change (if a service was reduced, suspended or denied).

If ODP does not locate documentation to substantiate that due process rights were issued in any of the above circumstances, ODP will instruct the AE to locate missing documentation or, when not available, provide written notification of due process rights to the participant/surrogate. The information is recorded in HCSIS or the ISP Signature Page is completed where applicable with a note acknowledging that the notification is late. If a participant's record indicates more than one instance in which notification of due process rights was not issued, the AE may provide to the participant a one-time written notification that includes an explanation for each instance late. The AE is expected to document remediation actions and submit the documentation to ODP within 30 days.

Remediation for Performance Measures a.i.6 through a.i.8 are continued in the Main Module Section B entitled Additional Needed Information (Optional).

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

	Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**
  Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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 one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
[ ] Aged or Disabled, or Both - General					
	[ ]	Aged			[ ]
	[ ]	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			[ ]
	[✓]	Intellectual Disability	3		[✓]
[ ] Mental Illness					
	[ ]	Mental Illness			
	[ ]	Serious Emotional Disturbance			

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

Residents of licensed Personal Care Homes are excluded from enrollment in the Consolidated Waiver.

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:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

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:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

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	17637
Year 2	17807
Year 3	17867
Year 4	17982
Year 5	18097

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	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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:

Purposes	

Unanticipated Emergencies
Money Follows the Person/Litigation
Hospital/Rehabilitation Care

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Unanticipated Emergencies

Purpose *(describe):*

ODP will reserve capacity for individuals/participants that are identified as meeting the unanticipated emergency criteria in accordance with ODP's unanticipated emergency policy. All participants enrolled in the Waiver have comparable access to all services offered in the Waiver regardless of whether he or she is enrolled due to meeting reserved capacity criteria or the criteria for emergency status in PUNS. This is evidenced by the Individual Support Plan process that is required for all participants and requires that service options be promoted and fully explored with every individual.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is determined by the historical number of unanticipated emergency enrollments in a fiscal year.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	20
Year 2	50
Year 3	20
Year 4 (renewal only)	20
Year 5 (renewal only)	20

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Money Follows the Person/Litigation

Purpose *(describe):*

ODP will reserve capacity for individuals identified to move from state operated ICF/ID Centers or private ICF/ID Centers and for individuals identified for enrollment through litigation. All participants enrolled in the Waiver have comparable access to all services offered in the Waiver regardless of whether he or she is enrolled due to meeting reserved capacity criteria or the criteria for emergency status in PUNS. This is evidenced by the Individual Support Plan process that is required for all participants and requires that service options be promoted and fully explored with every individual.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is determined by the number of individuals identified to move from state operated ICF/ID Centers and private ICF/ID Centers and for individuals identified for enrollment through litigation. These reserved capacity enrollments are based on the Money Follows the Person initiatives and budget adjustments.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	170
Year 2	120
Year 3	120
Year 4 (renewal only)	95
Year 5 (renewal only)	85

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Hospital/Rehabilitation Care

Purpose *(describe):*

ODP reserves waiver capacity for waiver participants requiring hospital/rehabilitation care beyond 30 consecutive days and up to 6 consecutive months from the first date of leave. Settings which are considered hospital/rehabilitation care include medical and psychiatric hospital settings, rehabilitation care programs and nursing homes. Settings which are not considered hospital/rehabilitation care include residential treatment facilities, state mental health hospitals, approved private schools and private and state ICFs/ID. All participants enrolled in the Waiver have comparable access to all services offered in the Waiver regardless of whether he or she is enrolled due to meeting reserved capacity criteria or the criteria for emergency status in PUNS. This is evidenced by the Individual Support Plan process that is required for all participants and requires that service options be promoted and fully explored with every individual.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is determined by the historical average number of participants who have been on hospital/rehabilitation leave for more than 30 consecutive days and up to 6 consecutive months.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	750
Year 2	750
Year 3	750
Year 4 (renewal only)	750
Year 5 (renewal only)	750

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

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:

The Commonwealth makes this assignment based on current enrollment in the Administrative Entity (AE) jurisdiction and expected need for access based on review of Prioritization of Urgency of Need for Services (PUNS) across the state. Capacity is allocated based on the size of the AE. Additional Waiver capacity is committed based on information captured through the standardized PUNS form, which is entered in HCSIS.

AEs are responsible to ensure PUNS information is current. In accordance with the AE Operating Agreement, if unused capacity exists with an AE, the capacity may be held and authorized at the state level and/or the state may commit the unused capacity to another AE based on need. Additionally, ODP may commit additional capacity to an AE based on unanticipated emergencies.

The AE is responsible to evaluate the PUNS categorization of a Waiver applicant when making enrollment decisions. Waiver applicants assessed by the AE must meet the criteria for emergency status in PUNS to be enrolled in the Waiver. ODP retains ultimate authority to select individuals for Waiver enrollment based on an individual''s unique emergency circumstances.

Participants may choose to receive services from a qualified and willing provider anywhere in Pennsylvania or a state contiguous to Pennsylvania as permitted in Appendix C of this Waiver. Medicaid Waiver services available through ODP are accessible statewide. If a participant is enrolled in the Waiver and chooses to relocate to a different county, the county where the participant resides has two options: 1) the county may choose to continue to provide administrative services to the participant in accordance with the AE Operating Agreement; or 2) the county may choose to transfer this responsibility and corresponding waiver capacity to the county where the participant is moving. If the second option is chosen the receiving county must accept the participant's transfer. The participant's Individual Service Plan and Waiver effective date will not be affected by the transfer.

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

The AE is responsible to identify an individual for Waiver enrollment when capacity becomes available. Services should begin within 45 calendar days of the Waiver enrollment date, unless otherwise indicated in the ISP (e.g. participantÃ‚Â's choice of provider delays service start, participantÃ‚Â's medical or personal situation impedes planned start date). Any delays in the initiation of a service after 45 calendar days must be discussed with the participant or surrogate and agreed to by the participant or their surrogate. ODP policy specifies that Waiver enrollment must be offered to individuals most in need as identified by the PUNS status (emergency). ODP retains ultimate authority to select individuals for Waiver enrollment based on an individual'ÃÂ's emergency circumstances.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: 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)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [x] **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)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **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)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only 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 MA 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 dollar amount:

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without spenddown 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%.**

Specify percentage amount:

- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 *(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 Item B-5-b (SSI State) and Item B-5-d)
  - ( ) **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State). 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-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. 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. 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:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this

section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

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:**

  Specify 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:

- (selected) **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.**

Appendix B: Participant Access and Eligibility

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 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: 1

ii. **Frequency of services.** The State requires (select one):

- **The provision of waiver services at least monthly**
- (selected) **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:

Supports Coordination is a Waiver service; however, it is excluded from the following monthly Waiver service requirement and shall not be considered when determining the frequency of services outlined below.

Supports Coordinators are responsible for verifying and monitoring that each Waiver participant receives at least one of the following Waiver services each calendar month to remain eligible for Waiver services:

•Home and Community Habilitation (Unlicensed);
•Licensed Day Habilitation;
•Prevocational Services;
•Residential Habilitation;
•Companion;
•Supported Employment;

•Transitional Work Services; and/or
•Transportation.

The following are exceptions to the requirement for at least one Waiver service each calendar month:

•The Waiver participant is admitted to a medical facility (for example, hospital, rehabilitation facility, nursing home) for up to 30 consecutive calendar days.

•The Waiver participant requires an emergency relocation (for example, due to a fire) and is unable to access Waiver services for up to 30 consecutive calendar days.

•When a Waiver participant is in need of one or more of the following Waiver services:
-Education Support Services;
-Homemaker/Chore;
-Respite;
-Nursing;
-Therapy Services;
-Supports Broker Services;
-Assistive Technology;
-Behavioral Support;
-Home Accessibility Adaptations;
-Vehicle Accessibility Adaptations; and/or
-Specialized Supplies.

Supports Coordination monitoring of participants requirements can be found in Appendix D-2-a. If a monthly service is not provided, ODP requires a face-to-face ISP monitoring contact by Supports Coordinators at least once every calendar month, regardless of the participant's living arrangement. At least two of the face-to-face visits per calendar year must take place in the participant's home.

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 an entity under contract with the Medicaid agency.**

Specify the entity:

- **Other**

Specify:

A Qualified Mental Retardation Professional (which remains a federal term, will now be referred to by ODP as Qualified Intellectual Disability Professional [QIDP]) is responsible for performing level of care evaluations and reevaluations. QIDPs are employed by AEs.

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:

The QIDP must have one of the following:
•A master's degree or higher level of education from an accredited college or university and one year of work experience working directly with persons with intellectual disabilities;

•A bachelor's degree from an accredited college or university and two years work experience working directly with persons with intellectual disabilities; or

•An associate's degree or 60 credit hours from an accredited college or university and four years work experience working directly with persons with intellectual disabilities.

The AE is responsible to ensure that no conflict of interest exists in the level of care evaluation/reevaluation process. Evaluations/reevaluations will not be accepted from:

•A QIDP employed or affiliated with an ICF/ID or nursing facility from which an individual is being referred or discharged.

•A QIDP employed or affiliated with an agency that provides or may provide Waiver funded services for the participant. The only exception to this rule is when an AE delegates the QIDP function to a Waiver provider with ODP approval; this QIDP may certify an individual's ICF/ID level of care as long as the individual is not on the QIDP's current caseload.

AEs may contract with another agency or independent professional who meets the criteria defined in 42 CFR 483.430 (a) to obtain a QIDP certification of need for an ICF/ID level of care in order to ensure a conflict-free determination.

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.

The AEs are responsible for the completion of an evaluation of need for level of care, and timely renewal annually thereafter. The initial evaluation and any reevaluation will be performed by a QIDP, as defined in 42 CFR 483.430 (a).

There are three fundamental criteria that must be met prior to an individual being determined eligible for an ICF/ID level of care:

1.Require active treatment as defined in the Waiver in Appendix B-6-a;

2.Have a diagnosis of intellectual disability. While ODP is using the term intellectual disability throughout the Waiver, there have been no changes in the eligibility criteria for determining a diagnosis of mental retardation; and

3.Be recommended for an ICF/ID level of care based on a medical evaluation.

An individual shall meet the criteria for requiring active treatment only when a QIDP, based on review of the individual's social and psychological history, determines that the individual will benefit from a professionally developed and supervised program of activities, experiences or therapies that are necessary for assisting the individual to function at his/her greatest physical, intellectual, social or vocational level.

For individuals for whom no further positive growth is demonstrated, the criteria shall be met by the QIDP's determination that a program of active treatment is needed to prevent regression or loss of current optimal functional status. The evaluation of the individual's social and psychological history shall consist of a review of notes, observations and reports from educational facilities, human service agencies, hospitals and other reliable sources when available. The review shall be done in conjunction with the individual's team.

Individuals who do not qualify for an ICF/ID level of care will be referred as appropriate to other agencies and resources.

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:

The same process is used for both the initial evaluation and subsequent reevaluations.

There are three fundamental criteria that must be met prior to an individual being determined eligible for an ICF/ID level of care:

1.Require active treatment;

2.Have a diagnosis of intellectual disability; and

3.Be recommended for an ICF/ID level of care based on a medical evaluation.

An individual shall meet the criteria for requiring active treatment only when a QIDP, based on review of the individual's social and psychological history, determines that the individual will benefit from a professionally developed and supervised program of activities, experiences or therapies that are necessary for assisting the individual to function at his/her greatest physical, intellectual, social or vocational level.

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:

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):*

In accordance with the AE Operating Agreement, the AE is responsible to complete the recertification of need for an ICF/ID level of care within 365 days of the participant's initial certification and subsequent anniversary dates of recertifications. The recertification shall be completed through a medical evaluation and by a QIDP and shall be based on the participant's continuing need for an ICF/ID level of care, his/her progress toward meeting plan objectives, the appropriateness of the Individual Support Plan, and consideration of alternate methods of care. On a monthly basis, ODP generates and distributes to the specific AE HCSIS reports identifying annual level of care redetermination compliance and noncompliance data.

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:

Records are maintained at the AE office where the participant is currently registered, as per the AE Operating

Agreement.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.a.1 Number and percent of new enrollees who have a LOC completed prior to entry into the waiver. Percent = number of new enrollees who have a LOC completed prior to entry into the waiver/number of new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe

		Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.b.1 Number and percent of annual LOC redeterminations completed within 365 days of the prior review. Percent = number of LOC redeterminations completed within 365 days of the prior review/number of redeterminations that are due.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.c.1 Number and percent of LOC initial determinations and redeterminations completed according to ODP policies and procedures. Percent = number of LOC initial determinations and redeterminations completed according to ODP policies and procedures/number of LOC determinations and redeterminations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5

		Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.c.2 Number and percent of initial LOC determinations and redeterminations that were completed accurately. Percent = number of initial LOC determinations and redeterminations that were completed accurately/number of LOC determinations and redeterminations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

For Performance Measures a.i.a.1 and a.i.b.1, a 100% review of data from HCSIS is conducted monthly by ODP staff to assess compliance.

For Performance Measures a.i.c.1. and a.i.c.2, ODP staff use the AEOM tool and methodology to review a proportionate, representative random sample of waiver participant records annually.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Performance Measure: a.i.a.1. Number and percent of new enrollees who have a LOC completed prior to entry into the waiver.
On a monthly basis, ODP generates and distributes to the specific AE, HCSIS reports identifying initial level of care (LOC) compliance and noncompliance data. The reports include a list of exceptions for that AE (any individual for whom a level of care evaluation is not entered into HCSIS as completed prior to the waiver start date). The AE is responsible to review these reports and provide remediation for any situation where a LOC has not been completed prior to waiver enrollment. Remediation will include completion of LOC documents and/or data entered into HCSIS. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification. If the LOC evaluation results in a finding that the participant is not eligible, the participant will be disenrolled from the Waiver and referred to other appropriate resources and payment for any waiver services provided will be recouped. The Department will initiate actions as needed to resolve any outstanding issues with AE performance using the methodology outlined in the AE Operating Agreement.

Performance Measure a.i.b.1. Number and percent of annual LOC redeterminations that are completed within 365 days of the prior review.
On a monthly basis, ODP generates and distributes to the specific AE, HCSIS reports identifying annual LOC redetermination compliance and noncompliance data. The reports include a list of exceptions for that AE (any participant for whom a LOC recertification is not entered into HCSIS within 365 days of the prior certification or recertification). The AE is responsible to review these reports and provide remediation for any situation where a LOC recertification has not been completed within 365 days. Remediation will include completion of LOC documents and/or LOC redetermination date entered into HCSIS. In cases in which repeated efforts to secure the supporting information from a waiver participant are unsuccessful, advance notice may be issued to terminate a participant's enrollment in the waiver. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification. The Department will initiate actions as needed to resolve any outstanding issues with AE performance using the methodology outlined in the AE Operating Agreement.

Performance Measure a.i.c.1. Number and percent of LOC initial determinations and redeterminations completed according to ODP policies and procedures.
Through the AEOMP, ODP evaluates whether initial LOC determinations and annual LOC redeterminations are completed according to ODP policies and procedures. The AE must locate or complete LOC evaluations using ODP's standardized forms and process in cases where the documentation is not present during the onsite review. If the participant is found ineligible for waiver services, disenrollment procedures will be initiated, the participant will be referred to other appropriate resources and payment for any waiver services provided during the timeframe the participant was ineligible will be recouped. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification. The Department will initiate actions as needed to resolve any outstanding issues with AE performance using the methodology outlined in the AE Operating Agreement.

Performance Measure a.i.c.2. Number and percent of initial LOC determinations and redeterminations that were completed accurately.
Through the AEOMP, ODP evaluates whether initial LOC determinations and annual LOC redeterminations are completed accurately. The AE is required to locate or complete required documentation that is not present or does not contain the necessary information during the onsite review, including the medical evaluation that documents a recommendation for ICF/ID LOC, a psychological evaluation that contains the results of a standardized general intelligence test that certifies the individual has a diagnosis of intellectual disability/significantly sub-average intellectual functioning, a Standardized Adaptive Assessment indicating impairments in adaptive behavior, and documentation that the individual had conditions of intellectual and adaptive functioning manifested during the developmental period which is from birth up to the individual's 22nd birthday. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days. When documentation is located or completed and eligibility in any one of the criteria is not met, disenrollment procedures will be initiated as per ODP policies and procedures and HCSIS amended as appropriate. If a determination is made that an AE is incorrectly applying the criteria and making determinations that are incorrect, targeted technical assistance is provided to the AE in order to ensure they fully understand the process and apply it correctly. The Department will initiate actions as needed to resolve any outstanding issues with AE performance using the methodology outlined in the AE Operating Agreement.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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).

The AE is required to assure that all individuals requesting services who are likely to require an ICF/ID level of care, or their legal representatives, are informed of feasible home and community-based services funded under the waiver. Feasible alternatives include sufficient and appropriate home and community based services and support that the individual needs or is likely to need in the home and community. This requirement must be met before an individual is given the choice of service delivery preference to receive Medicaid funded services in an ICF/ID or in their home and community under the waiver.

The AE is required to ensure that the waiver participant is free to choose services in any Pennsylvania county. The AE responsible for the geographic area where the individual resides or is planning to reside is required to provide information about both home and community-based services and ICF/ID services, and to assist the individual or his/her legal representative in contacting home and community-based service providers, other AEs and ICF's/ID as requested. AEs that receive requests for information about services in a geographic area outside of the AE's responsibility are required to provide the requested information along with other assistance that may be necessary.

ODP currently utilizes standard forms to document requests for waiver services or changes in waiver services and service delivery preference.

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.

ODP currently utilizes standard forms to document requests for waiver services or changes in waiver services and service delivery preference. Completed forms are maintained at the AE offices where the participant is registered, as per the AE Operating Agreement.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency 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):
Each AE is required to provide accommodations to any individual/participant enrolled or enrolling with an AE while performing their administrative functions. Accommodations include but are not limited to: oral interpretation, written translation and language lines. AEs are also required to have and implement policies/procedures for ensuring language assistance services to people who have limited proficiency in English, in accordance with Title VI and corresponding ODP policy.

The policies/procedures must include a statement noting that each participant will be assessed regarding their proficiency in the English language; that documentation will be maintained in the participant's record indicating the participant's need for language assistance and the resources utilized to provide this assistance; the assessment of language assistance resources and the development of a resource bank accessible to all staff members needing to provide services to a person with limited English proficiency; a procedure for ongoing staff training; and a procedure for monitoring compliance with Title VI, which can be part of the AE's quality management program.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Education Support Services**		
Statutory Service	**Home and Community Habilitation (Unlicensed)**		
Statutory Service	**Homemaker/Chore**		
Statutory Service	**Licensed Day Habilitation**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment - Job Finding and Job Support**		
Statutory Service	**Supports Coordination**		
Extended State Plan Service	**Nursing**		
Extended State Plan Service	**Therapy Services**		
Supports for Participant Direction	**Supports Broker Services**		
Other Service	**Assistive Technology**		
Other Service	**Behavioral Support**		
Other Service	**Companion**		
Other Service	**Home Accessibility Adaptations**		

Other Service	**Specialized Supplies**
Other Service	**Transitional Work Services**
Other Service	**Transportation**
Other Service	**Vehicle Accessibility Adaptations**

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Education

Alternate Service Title (if any):

Education Support Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope)*:

Education Support Services consist of special education and related services as defined in Sections (16) and (17) of the Individuals with Disabilities Education Act (IDEA) to the extent that they are not available under a program funded by IDEA or available for funding by the Office of Vocational Rehabilitation (OVR). Education Support Services may consist of general adult educational services including community college, university or other college-level courses, classes, tutoring to receive a General Educational Development (GED) degree, and support to the participant to participate in an apprenticeship program. Participants authorized for Education Support Services must have an employment outcome or an outcome related to skill attainment or development which is documented in the ISP and is related to the Education Support Service need.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. Refer to the Provider Specification section below for criteria on provider requirements.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☑ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Education Support Services

Provider Category:
Individual

Provider Type:
Individual

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Certification required by the PA Department of Education or contiguous state where the service is provided for the subject being taught.

Other Standard *(specify)*:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Agree to carry out the Education Support outcomes included in the ISP.

3.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee

Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Education Support Services

Provider Category:
Agency

Provider Type:
Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Certification required by the PA Department of Education or contiguous state where the service is provided for the subject being taught.
Other Standard *(specify):*
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Comply with Department standards related to provider qualifications.

Staff working for or contracted with the agency must meet the following standards:
1.Agree to carry out the Education Support outcomes included in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Habilitation

Alternate Service Title (if any):
Home and Community Habilitation (Unlicensed)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
This is a direct service (face-to-face) provided in home and community settings to assist participants in acquiring, maintaining, and improving self-help, domestic, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Services consist of support in the general areas of self-care, communication, fine and gross motor skills, mobility, personal adjustment, relationship development, socialization, and use of community resources. When services are provided by agency-based providers, this service also includes transportation services necessary to enable the participant to participate in the Home and Community Habilitation Service, in accordance with the participant's ISP. Through the provision of this service participants will acquire, maintain, or improve skills necessary for participants to live in the community, to live

more independently, or to be more productive and participatory in community life.

Participants receiving Residential Habilitation Services may elect to receive Home and Community Habilitation Services as an alternative to a licensed Day Habilitation or Prevocational Services. Under these circumstances the Home and Community Habilitation Service must occur anytime during the hours of 8:00 am – 5:00 pm, Monday through Friday. Refer to the service limit section below for information related to unit limitations when this occurs.

Home and Community Habilitation Services may provide the following supports to meet participants' habilitative outcomes as documented in the ISP:

1.Support that enables the participant to access and use community resources such as instruction in using transportation, translation and communication assistance related to a habilitative outcome, and services to assist the participant in shopping and other necessary activities of community life.

2.Support that assists the participant in developing or maintaining financial stability and security, such as plans for achieving self-support; general banking; personal and estate planning; balancing accounts; preparing income taxes; and recordkeeping.

3.Support that enables a participant to participate in community projects, associations, groups, and functions, such as support that assists a participant to participate in a volunteer association or a community work project.

4.Support that enables a participant to visit with friends and family in the community.

5.Support that enables a participant to participate in public and private boards, advisory groups, and commissions.

6.Support that enables the participant to exercise rights as a citizen, such as assistance in exercising civic responsibilities.

7.Support provided during overnight hours when the participant needs the habilitation service to protect their health and welfare. The staff providing the Home and Community Habilitation Service must be awake. If the participant only needs supervision during overnight hours, the appropriate service is Companion Services.

This service may be provided at the following levels:
• Basic Staff Support - The provision of the service at a staff-to-individual ratio of no less than 1:6.

• Level 1 - The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.

• Level 2 - The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.

• Level 3 - The provision of the service at a staff-to-individual ratio of 1:1.

• Level 3 Enhanced - The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who has at least a 4 year degree or is a licensed nurse.

• Level 4 - The provision of the service at a staff-to-individual ratio of 2:1.

• Level 4 Enhanced - The provision of the service at a staff-to-individual ratio of 2:1 with staff members who have at least a 4 year degree or who are a licensed nurse.

The use of enhanced levels of service is based on the participant's assessed need, not the service worker's personal qualifications. The fact that the service worker possesses a degree is not justification to use the enhanced level of service.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Home and Community Habilitation may not be provided at the same time as any of the following: Companion Services, the direct portion of Supported Employment, Licensed Day Habilitation, Prevocational Services and Transitional Work Services. Home and Community Habilitation and Companion Services have a maximum limit of 24 hours (96 15-minute units) per participant per calendar day whether used in combination or alone.

This service may be provided at the same time as Therapy, Nursing, and Behavioral Support Services. All providers should coordinate schedules and service delivery to ensure consistency in services to participants.

As indicated above for participants residing in residential settings, Home and Community Habilitation Services may be used as an alternative either part-time or full-time for a Licensed Day Habilitation Service or a Prevocational Service. When this occurs the Home and Community Habilitation units are included in the combined unit limit for services that may not exceed 40 hours (160 15-minute units) per participant, per calendar week based on a 52 week year (Transitional Work Services, Supported Employment Services, licensed Day Habilitation Services and Prevocational Services).

Home and Community Habilitation Services cannot be provided in a licensed setting or camp. This service is provided in a participant's private home or other community setting.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency - Unlicensed Habilitation

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home and Community Habilitation (Unlicensed)

Provider Category:
Individual

Provider Type:
Individual

Provider Qualifications

License *(specify)*:
Must be a Licensed Nurse when providing enhanced levels of Home and Community Habilitation and the participant's assessed needs require a licensed nurse provide the service.

Certificate *(specify)*:
Must have at least a 4 year degree when providing enhanced levels of Home and Community Habilitation and the participant's assessed needs require the degree.

Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Home and Community Habilitation Service.

Other Standard *(specify)*:
1.Be a legal resident of Pennsylvania or a state contiguous to Pennsylvania with supporting documentation (for SSWs).

2.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania (for an individual that is not a SSW).

3.Be at least 18 years of age.

4.Complete necessary pre/in-service training based on the ISP.

5.Agree to carry out the Home and Community Habilitation outcomes included in the ISP.

6.Be trained to meet the unique needs of the participant which includes, but is not limited to, communication, mobility and behavioral needs.

7.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

8.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

9.Have automobile insurance for all automobiles that are owned, leased, and/or hired and used as a component of the Home and Community Habilitation Service.

10.Have a valid driver's license if the operation of a vehicle is necessary to provide Home and Community Habilitation Services.

11.Have Workers' Compensation Insurance in accordance with state statute or in accordance with ODP FMS policies.

12.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home and Community Habilitation (Unlicensed)

Provider Category:

Agency

Provider Type:

Agency - Unlicensed Habilitation

Provider Qualifications

License *(specify):*

Employees (direct, contracted, or in a consulting capacity) providing enhanced levels of Home and Community Habilitation must be a Licensed Nurse when the participant's assessed needs require a licensed nurse provide the service.

Certificate *(specify):*

Employees (direct, contracted, or in a consulting capacity) providing enhanced levels of Home and Community Habilitation must have at least a 4 year degree when the participant's assessed needs require the degree.

Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Home and Community Habilitation Service.

Other Standard *(specify):*

Agencies must meet the following standards:

1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Home and Community Habilitation Service.

4.Have Workers' Compensation Insurance in accordance with state statute.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

6.Comply with Department standards related to provider qualifications.

Staff working for or contracted with the agency must meet the following standards:
1.Be at least 18 years of age.

2.Complete necessary pre/in-service training based on the ISP.

3.Agree to carry out the Home and Community Habilitation outcomes included in the ISP.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Have a valid driver's license if the operation of a vehicle is necessary to provide Home and Community Habilitation Services.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Homemaker

Alternate Service Title (if any):
Homemaker/Chore

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Homemaker services consist of services to enable the participant or the family member(s) or friend(s) with whom the participant resides to maintain their primary private home. This service can only be provided when a household member is temporarily absent or unable to manage the home, or when no landlord or provider agency staff is responsible to perform the homemaker activities. Homemaker Services must be provided by a qualified homemaker and may include cleaning and laundry, meal preparation, and other general household care. Chore services consist of services needed to maintain the home in a clean, sanitary, and safe condition. This service can only be provided in the following situations:

• Neither the participant, nor anyone else in the household, is capable of performing and financially providing for the function; and

• No other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for the provision.

Chore services consist of heavy household activities such as washing floors, windows, and walls; tacking down loose rugs and tiles; moving heavy items of furniture in order to provide safe access and egress; ice, snow, and/or leaf removal; and yard maintenance. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Maintenance in the form of upkeep and improvements to the participant's home is excluded from federal financial participation.

This service must be delivered in Pennsylvania in the participant's private home. Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is limited to 40 hours per participant per fiscal year when the participant or family member(s) or friend(s) with whom the participant resides is temporarily unable to perform and financially provide for the homemaker/chore functions. A person is considered temporarily unable when the condition or situation that prevents them from performing and financially providing for the homemaker/chore functions is expected to improve. There is no limit when the participant lives independently or with family member(s) or friend(s) who are permanently unable to perform and financially provide for the homemaker/chore functions.

A person is considered permanently unable when the condition or situation that prevents them from performing and financially providing for the homemaker/chore functions is not expected to improve. The ISP team is responsible to determine whether a person is temporarily or permanently unable to perform and financially provide for the homemaker/chore functions. The ISP team's determination should be documented in the ISP.

This service is not available to participants residing in agency-owned, rented, leased, or operated homes.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Homemaker
Agency	Homemaker/Chore Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker/Chore

Provider Category:
Individual

Provider Type:
Individual Homemaker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
1.Be a legal resident of Pennsylvania or a state contiguous to Pennsylvania with supporting documentation (for SSWs).

2.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania (for an individual that is not a SSW).

3.Be at least 18 years of age.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Have Workers' Compensation Insurance in accordance with state statute or in accordance with ODP FMS policies.

7.Agree to carry out the Homemaker/Chore outcomes included in the ISP.

8.Be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

9.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee

Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker/Chore

Provider Category:
Agency

Provider Type:
Homemaker/Chore Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies must meet the following standards:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have Workers' Compensation Insurance in accordance with state statute.

4.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes, but is not limited to: communication, mobility and behavioral needs.

5.Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies must meet the following standards:
1.Be at least 18 years of age.

2.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

4.Agree to carry out the Home maker/Chore outcomes included in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Day Habilitation

Alternate Service Title (if any):
Licensed Day Habilitation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Licensed Day Habilitation is a direct service (face-to-face) that consists of supervision, training, and support in general areas of self-care, communication, community participation, and socialization. Areas of emphasis include: therapeutic activities, fine and gross motor development, mobility, personal adjustment, use of community resources, and relationship development.

The service also includes transportation that is an integral component of the service; for example, transportation to a community activity. The Licensed Day Habilitation provider is not, however, responsible for transportation to and from a participant's home.

This service may be provided in the following settings at the following levels:

Adult Training facilities (55 Pa. Code Chapter 2380)
• Basic Staff Support - The provision of the service at a staff-to-individual ratio of no less than 1:6.

• Level 1 - The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.

• Level 2 - The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.

• Level 3 - The provision of the service at a staff-to-individual ratio of 1:1.

• Level 3 Enhanced - The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who has at least a 4 year degree or is a licensed nurse.

• Level 4 - The provision of the service at a staff-to-individual ratio of 2:1.

• Level 4 Enhanced - The provision of the service at a staff-to-individual ratio of 2:1 with staff members who have at least a 4 year degree or who are a licensed nurse

Older Adult Daily Living Centers (6 Pa. Code Chapter 11)
• Older Adult Day

The use of enhanced levels of service is based on the participant's assessed need, not the service worker's personal qualifications. The fact that the service worker possesses a degree is not justification to use the enhanced level of service.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
When Licensed Day Habilitation services are provided alone or in conjunction with Prevocational, Transitional Work or Supported Employment services, the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 40 hours (160 15-minute units) per participant per calendar week based on a 52-week year.

Licensed Day Habilitation may not be provided at the same time as any of the following: Companion Services, the direct portion of Supported Employment, Home and Community Habilitation, Prevocational Services and Transitional Work Services.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Licensed Day Habilitation

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify):*
Providers with a waiver service location in Pennsylvania must be licensed as Adult Training Facilities 55 Pa. Code Chapter 2380 or Older Adult Day Services 6 Pa. Code Chapter 11.

A comparable license is required for providers with a waiver service location in states contiguous to Pennsylvania.

Employees (direct, contracted, or in a consulting capacity) providing enhanced levels of Licensed Day Habilitation Service must be a Licensed Nurse when the participant's assessed needs require a licensed nurse provide the service.
Certificate *(specify):*
Employees (direct, contracted, or in a consulting capacity) providing enhanced levels of Licensed Day Habilitation service must have at least a 4 year degree when the participant's assessed needs require the degree.

Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Licensed Day Habilitation Service.
Other Standard *(specify):*
Agencies must meet the following standards:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Licensed Day Habilitation Service.

4.Have Workers' Compensation Insurance in accordance with state statute.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

6.Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies must meet the following standards:
1.Be at least 18 years of age.

2.Complete necessary pre/in-service training based on the ISP.

3.Agree to carry out the Licensed Day Habilitation outcomes included in the ISP.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Have a valid driver's license if the operation of a vehicle is necessary to provide Licensed Day Habilitation Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Prevocational Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service is provided to assist participants in developing skills necessary for placement into competitive employment. Prevocational Services focus on the development of competitive worker traits through the use of work as the primary training method. The service may be provided as:

•Occupational training which is used to teach skills for a specific occupation in the competitive labor market, and includes personal and work adjustment training that is designed to develop appropriate worker traits and teach the understanding of the expectations of a work environment.

•Work related evaluation which involves the use of planned activities, systematic observation, and testing to accomplish a formal assessment of the participant, including identification of service needs, potential for employment, and identification of employment objectives.

Participants receiving Prevocational Services must have an outcome for employment included in their ISP. The service must be reviewed at least every 6 months or more frequently as needed to assess the need for the service and progress on the employment outcome.

The service also includes transportation that is an integral component of the service, for example, transportation to a work activity. The Prevocational provider is not, however, responsible for transportation to and from a participant's home.

This service may be provided at the following levels:
•Basic Staff Support - The provision of the service at a staff-to-individual ratio of no less than 1:15.

•Level 1 - The provision of the service at a staff-to-individual ratio range of <1:15 to 1:7.5.

•Level 2 - The provision of the service at a staff-to-individual ratio range of <1:7.5 to >1:1.

• Level 3 - The provision of the service at a staff-to-individual ratio of 1:1.

• Level 3 Enhanced - The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who has at least a 4 year degree or is a licensed nurse.

• Level 4 - The provision of the service at a staff-to-individual ratio of 2:1.

• Level 4 Enhanced - The provision of the service at a staff-to-individual ratio of 2:1 with staff members who have at least a 4 year degree or who are a licensed nurse.

The use of enhanced levels of service is based on the participant's assessed need, not the service worker's personal qualifications. The fact that the service worker possesses a degree is not justification to use the enhanced level of service.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Handicapped employment as defined in Title 55, Chapter 2390 may not be funded through the Waiver.

Prevocational Services may not be funded through the Waiver if they are available to participants through program funding under Section 110 of the Rehabilitation Act of 1973, as amended, or section 602 (16) and (17) of the IDEA. Documentation must be maintained in the participant's file to satisfy assurances that the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 as amended and the IDEA.

When Prevocational Services are provided alone or in conjunction with Licensed Day Habilitation Services, Transitional Work or Supported Employment services, the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 40 hours (160 15-minute units) per participant per calendar week based on a 52-week year.

Prevocational Services may not be provided at the same time as any of the following: Companion Services, the direct portion of Supported Employment, Licensed Day Habilitation, Home and Community Habilitation and Transitional Work Services.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications

License *(specify):*
Providers with a waiver service location in Pennsylvania must be licensed under Prevocational Services 55 Pa. Code Chapter 2390.

A comparable license is required for providers with waiver service locations in states contiguous to Pennsylvania.

Employees (direct, contracted, or in a consulting capacity)providing enhanced levels of Prevocational Service must be a Licensed Nurse when the participant's assessed needs require a licensed nurse provide the service.

Certificate *(specify):*
Employees (direct, contracted, or in a consulting capacity) providing enhanced levels of Prevocational Service must have at least a 4 year degree when the participant's assessed needs require the degree.

Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Prevocational Service.

Other Standard *(specify):*
Agencies must meet the following standards:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Prevocational Service.

4.Have Workers' Compensation Insurance in accordance with state statute.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

6.Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies must meet the following standards:
1.Be at least 18 years of age.

2.Complete necessary pre/in-service training based on the ISP.

3.Agree to carry out the Prevocational outcomes included in the ISP.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S.

Chapter 63.

6.Have a valid driver's license if the operation of a vehicle is necessary to provide Prevocational Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Habilitation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

These are direct (face-to-face) and indirect services provided to participants who live in licensed and unlicensed provider owned, rented/leased, or operated (i.e. licensed and unlicensed Family Living homes) residential settings. Residential Habilitation Services are provided to protect the health and welfare of participants who reside at the residential setting by assisting them in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Services consist of support in the general areas of self-care, communication, fine and gross motor skills, mobility, personal adjustment, relationship development, socialization, and use of community resources. Residential Habilitation may be provided up to 24 hours a day based on the needs of the participant receiving services. This service also includes transportation services that are necessary to enable the participant to access services and resources outlined in the ISP, including transportation to and from day or employment services. The Residential Habilitation provider is not responsible for transportation services for which another provider is responsible.

Residential Habilitation Services may not be provided in Personal Care Homes licensed by the Department (55 Pa. Code Chapter 2600). Residential Habilitation Services may only be provided in Domiciliary Care Homes if the home is licensed by the Department (55 Pa. Code 6400, 6500, 5310 and 3800) and is certified by the local

Area Agency on Aging (6 Pa. Code Chapter 21).

The residential home must be located in Pennsylvania, and must be one of the following eligible settings:
1.Child Residential Services (The residential section of 55 Pa. Code Chapter 3800, Child Residential and Day Treatment Facilities): The 55 Pa. Code Chapter 3800 services that may be funded through the Waiver are limited to residential service settings. Child residential services provided in secure settings, detention centers, mobile programs, outdoor programs, and residential treatment facilities accredited by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) may not be funded through the Waiver.

2.Community Residential Rehabilitation Services for the Mentally Ill (CRRS), (55 Pa. Code Chapter 5310): CRRS are characterized as transitional residential programs in community settings for participants with chronic psychiatric disabilities. This service is full-care CRRS for adults with intellectual disability and mental illness. Full-care CRRS for adults is a program that provides living accommodations for participants who are psychiatrically disabled and display severe community adjustment problems. A full range of personal assistance and psychological rehabilitation is provided for participants in a structured living environment. Host homes, as defined in section 5310.6 are excluded.

3.Family Living Homes (55 Pa. Code Chapter 6500): Family Living Homes are somewhat different than other licensed homes as these settings provide for lifesharing arrangements. Participants live in a host lifesharing home and are encouraged to become contributing members of the host lifesharing unit. The host lifesharing arrangement is chosen by the participant, his or her family and team and with the lifesharing host and Family Living Provider Agency in accordance with the participant's needs. Licensed Family Living Homes are limited to homes in which one or two participants with an intellectual disability who are not family members or relatives of the lifesharing host reside. The primary lifesharing host caregiver is able to receive relief based on the needs of the participant.

4.Community Homes for Individuals with Mental Retardation (55 Pa. Code Chapter 6400): A licensed Community Home is a home licensed under 55 Pa. Code Chapter 6400 where services are provided to individuals with an intellectual disability. A community home is defined in regulations as, "A building or separate dwelling unit in which residential care is provided to one or more individuals with mental retardation…." For homes licensed under 55 Pa. Code Chapters 6400, services may be provided up to the approved program capacity of the home. Approved program capacity is established by ODP for each licensed Chapter 6400 service location based on the maximum number of individuals who, on any given day, may be authorized to receive services at that service location. There may be situations in which a site's licensed capacity is greater than the approved program capacity. In these situations, the site may only provide services up to the approved program capacity.

5.Unlicensed Residential Habilitation: Residential Habilitation may be provided to participants who live in unlicensed provider-owned, rented, leased or operated family living homes:
-55 Pa. Code §6400.3(f)(7) (for Community Homes), excludes community homes that serve three or fewer individuals with an intellectual disability 18 years of age or older who need a yearly average of 30 hours or less of direct staff contact per week per home; or

-55 Pa. Code §6500.3(f)(5) (for Family Living Homes) excludes Family Living Homes that provide room and board for one or two individuals with an intellectual disability 18 years of age or older who need a yearly average of 30 hours or less of direct training and assistance per week per home from the Family Living Provider agency.

Residential Enhanced Staffing may be utilized for participants receiving Residential Habilitation Services. There are three possible add-ons to the Residential Habilitation Service based on the assessed need(s) of the participant:
1.The provision of the Residential Habilitation Service by licensed nurses for participants living in licensed and unlicensed residential habilitation settings. The need for an enhanced level of service must be due to the participants need for staff that are licensed nurses. The nursing license must be necessary to meet the needs of the participant;

2.The provision of Supplemental Habilitation staffing may be provided as part of the Residential Habilitation Service for participants living in licensed residential habilitation settings , to meet the temporary medical or behavioral needs of the participants when those needs cannot be met as a part of the usual residential habilitation staffing pattern; and/or

3.Additional Individualized Staffing may be provided as a part of the Residential Habilitation Service for participants living in licensed residential habilitation settings , to meet the long-term individualized staffing

needs of the participant when those needs cannot be met as a part of the usual residential habilitation staffing pattern.

Residential Habilitation Services must be delivered in Pennsylvania. During temporary travel, however, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. Refer to the Provider Specification section below for criteria on provider requirements.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

In order to receive Residential Habilitation Services, the residential habilitation setting where the participant resides must be located in Pennsylvania. All residential habilitation settings in which Residential Habilitation Services are provided must be integrated and dispersed in the community in noncontiguous locations, and may not be located on campus settings. To meet this requirement, the location of each residential habilitation setting must be separate from any other ODP-funded residential habilitation setting and must be dispersed in the community and not surrounded by, other ODP-funded residential habilitation settings. Residential habilitation settings where Residential Habilitation Services are provided should be located in the community and surrounded by the general public. New residential habilitation settings or changes to existing residential habilitation settings must be approved by ODP or its designee utilizing the ODP residential habilitation setting criteria.

Prior to Residential Habilitation Services being authorized, the ISP team and AE must utilize the ODP Residential Habilitation Service criteria in accordance with ODP policy which will assist in determining the participant's need for Residential Habilitation Services. These criteria are designed to support the selection of the least restrictive and most integrated setting for the Residential Habilitation Service that will meet the needs of the participant. Residential Habilitation Services must be reviewed at least every 6 months or more frequently using the ODP Residential Habilitation Service criteria to determine whether there is a continued need for the service.

The following services may not be authorized for participants who receive Residential Habilitation Services: Companion, Transportation, Homemaker/Chore, Supports Broker, Specialized Supplies and Home and Vehicle Accessibility Adaptations. The only exception is that Home and Vehicle Accessibility Adaptations may be authorized for participants residing in licensed and unlicensed family living homes when the home or vehicle being adapted and utilized by the participant is not owned, rented or leased by the family living provider agency.

Residential Enhanced Staffing must be prior authorized by ODP.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Residential Habilitation
Agency	Unlicensed Residential Habilitation

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Licensed Residential Habilitation

Provider Qualifications

License *(specify):*

Licensed Residential Habilitation providers with a waiver service location in Pennsylvania must be licensed under one of the following: 55 Pa. Code Chapter 6400, 55 Pa. Code Chapter 6500, 55 Pa. Code Chapter 3800, 55 Pa. Code Chapter 5310 or 6 Pa. Code Chapter 21 (this is only applicable when jointly licensed with one of the previous licenses).

Employees (direct, contracted, or in a consulting capacity) providing Residential Enhanced Staffing as an add-on must be a Licensed Nurse when the participant's assessed needs require that a licensed nurse provide the service.

Certificate *(specify):*

Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Residential Habilitation Service.

Other Standard *(specify):*

Agencies must meet the following standards:

1.Have a waiver service location in Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Residential Habilitation Service.

4.Have Workers' Compensation Insurance, when required by state statute.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

6.Comply with Department standards related to provider qualifications.

Staff working for or contracting with agencies must meet the following standards:

1.Be at least 18 years of age.

2.Complete necessary pre/in-service training based on the ISP.

3.Agree to carry out the Residential Habilitation outcomes included in the ISP.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have required child abuse clearances (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Have a valid driver's license if the operation of a vehicle is necessary to provide Residential Habilitation Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:
Unlicensed Residential Habilitation
Provider Qualifications
License *(specify):*
Employees (direct, contracted, or in a consulting capacity) providing Residential Enhanced Staffing as an add-on must be a Licensed Nurse when the participant's assessed needs require that a licensed nurse provide the service.
Certificate *(specify):*
Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Residential Habilitation Service.
Other Standard *(specify):*
Agencies must meet the following standards:
1.Have a waiver service location in Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Residential Habilitation Service.

4.Have Workers' Compensation Insurance, in accordance with state statute.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

6.Comply with Department standards related to provider qualifications.

Staff working for or contracting with agencies must meet the following standards:
1.Be at least 18 years of age.

2.Complete necessary pre/in-service training based on the ISP.

3.Agree to carry out the Residential Habilitation outcomes included in the ISP.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Have a valid driver's license if the operation of a vehicle is necessary to provide Residential Habilitation Services.
Verification of Provider Qualifications
Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Respite
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Respite Services are direct services that are provided to supervise and support participants living in private homes on a short-term basis due to the absence or need for relief of those persons normally providing care. Respite Services do not cover the care provided to a minor child when the primary caregiver or legally responsible individual is absent due to work.

The provision of Respite Services does not prohibit supporting participants' involvement in activities in the community during the period of respite. The provision of 24-hour Respite Services does not prohibit participants' involvement in Day and Employment services.

Participants can receive two categories of Respite Services: 24-hour respite and 15-minute respite. 24-hour respite is provided for periods of more than 16 hours, and is billed using a daily unit. 15-minute respite is provided for periods of 16 hours or less, and is billed using a 15-minute unit. Please see the following section for limitations on these services.

Room and board costs may only be included when the Respite Service is provided in a facility that is approved (licensed or accredited) by the state. Room and board costs may be included solely for Respite in a licensed residential setting or Respite in camp settings that are licensed or accredited.

Respite Services may only be provided in the following location(s):
•Participant's private home or place of residence located in Pennsylvania.

•Licensed Family Living Home (55 Pa. Code Chapter 6500) located in Pennsylvania.

•Licensed Community Home (55 Pa. Code Chapter 6400) located in Pennsylvania within the home's approved program capacity. ODP may approve the provision of Respite Services above a home's approved program capacity on a case-by-case basis.

•Licensed Child Residential Service Home (55 Pa. Code Chapter 3800) located in Pennsylvania.

•Licensed Community Residential Rehabilitation Services for the Mentally Ill Home (55 Pa. Code Chapter 5310) located in Pennsylvania.

•Unlicensed home of a provider or a private home that is located in Pennsylvania or a contiguous state.

•Other community settings such as camp where the setting meets applicable state or local codes and the provider of service meets the provider qualifications established by the Department.

Respite services may not be provided in Nursing Homes, Hospitals, Personal Care Homes or ICFs/ID.

This service may be provided at the following levels:
• Basic Staff Support - The provision of the service at a staff-to-individual ratio of 1:4.

• Level 1 - The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.

• Level 2 - The provision of the service at a staff-to-individual ratio range of 1:1.

• Level 2 Enhanced - The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who has at least a 4 year degree or is a licensed nurse.

• Level 3 - The provision of the service at a staff-to-individual ratio of 2:1.

• Level 3 Enhanced - The provision of the service at a staff-to-individual ratio of 2:1 with staff members who have at least a 4 year degree or who are a licensed nurse.

The use of enhanced levels of service is based on the participant‘s assessed need, not the service worker‘s personal qualifications. The fact that the service worker possesses a degree is not justification to use the enhanced level of service.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite Services are limited to:
•Participants residing in a private home. The only exception is for an emergency circumstance approved by ODP for participants who receive Residential Habilitation Services.

•30 units (days) of 24-hour Respite Services per participant in a period of one fiscal year except when extended by ODP using the standard ODP exception process.

•480 (15 minute) units of temporary Respite Services per participant in a period of one fiscal year except when extended by ODP using the standard ODP exception process.

Respite services may not be provided in Nursing Homes, Hospitals, Personal Care Homes or ICFs/ID.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:
Individual
Provider Qualifications
License *(specify):*
Must be a Licensed Nurse when providing enhanced levels of Respite Service and the participant's assessed needs require a licensed nurse provide the service.
Certificate *(specify):*
Must have at least a 4 year degree when providing enhanced levels of Respite Service and the participant's assessed needs require the degree.

Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Respite Service.
Other Standard *(specify):*
1.Be a legal resident of Pennsylvania or a state contiguous to Pennsylvania with supporting documentation (for SSWs).

2.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania (for an individual that is not a SSW).

3.Be at least 18 years of age.

4.Complete necessary pre/in service training based on the ISP.

5.Agree to carry out the Respite outcomes included in the ISP.

6.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

7.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

8.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Respite Service.

9.Have Workers' Compensation Insurance in accordance with state statute or in accordance with ODP FMS policies.

10.Be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

11.Comply with Department standards related to provider qualifications.
Verification of Provider Qualifications
Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Agency
Provider Qualifications
License *(specify):*

Providers with a waiver service location in Pennsylvania must be licensed as follows:
•55 Pa. Code Chapter 6400 when Respite is provided in Community Homes for people with intellectual disabilities;

•55 Pa. Code Chapter 6500 when Respite is provided in Family Living Homes;

•55 Pa. Code Chapter 3800 when Respite is provided in child residential homes; or

•55 Pa. Code Chapter 5310 when Respite is provided in licensed Community Residential Rehabilitation Services for the Mentally Ill Home.

A comparable license or certification is required for providers with waiver service locations in states contiguous to Pennsylvania.

Employees (direct, contracted, or in a consulting capacity) providing enhanced levels of Respite Service must be Licensed Nurses when the participant's assessed needs require a licensed nurse provide the service.
Certificate *(specify):*
Employees (direct, contracted, or in a consulting capacity) providing enhanced levels of Respite Service must have at least a 4 year degree when the participant's assessed needs require the degree.

Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Respite Service.
Other Standard *(specify):*
Agencies must meet the following standards:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Respite Service.

4.Have Workers' Compensation Insurance in accordance with state statute.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

6.Comply with Department standards related to provider qualifications.

Staff working for or contracted with the agency must meet the following standards:
1.Be at least 18 years of age.

2.Complete necessary pre/in service training based on the ISP.

3.Agree to carry out the Respite outcomes included in the ISP.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Have a valid driver's license if the operation of a vehicle is necessary to provide Respite Services.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment - Job Finding and Job Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported Employment Services are direct and indirect services that are provided in a variety of community employment work sites with co-workers who do not have disabilities for the purposes of finding and supporting participants in competitive jobs of their choice. Supported Employment Services enable participants to receive paid employment at minimum wage or higher from the employer. This service is provided to participants who, because of their disabilities, need additional support to perform in a work setting. Supported Employment Services include activities such as supervision and training needed by the participant in order to obtain and sustain paid work. Payment will be made only for the supervision, and training required by the participants receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Federal Financial Participation through the Waiver may not be claimed for incentive payments, subsidies, or unrelated vocational expenses such as the following:

•Incentive payments made to an employer of participants receiving services to encourage or subsidize the employer's participation in a supported employment program;

•Payments that are passed through to participants receiving supported employment; or

•Payments for vocational training that are not directly related to a participant's supported employment program.

Supported Employment Services consist of two components: job finding and job support. Job finding may include interview assistance, employer outreach and orientation, resume preparation, job searching, and preparation for job tasks. Other examples of activities that may be associated with job finding include participation in individual planning for employment; development of job seeking skills; development of customer-specific job skills; job analysis; support to learn job tasks; consultation with the Office of Vocational Rehabilitation (OVR), benefits counseling agencies, and provider networks under Ticket to Work on behalf of a participant; assistance in beginning a business; and outreach with prospective employers on behalf of the participant including consultation on tax advantages and other benefits.

Job support consists of training the participant receiving the service on job assignments, periodic follow-up

and/or ongoing support with participants and their employers. The service must be necessary for participants to maintain acceptable job performance and work habits including assistance in learning new work assignments, maintaining job skills, and achieving performance expectations of the employer. Other examples of activities that may be associated with job support include participation in individual planning for employment, direct intervention with an employer, employment related personal skills instruction, support to relearn job tasks, training to assist participants in using transportation to and from work, maintenance of appropriate work and interpersonal behaviors on the job, follow- along services at the work site after OVR funded services are discontinued, and technical assistance and instruction for the participant's co-workers that will enable peer support.

Ongoing use of the service is limited to support for participants that cannot be provided by the employer through regular supervisory channels and/or on-the-job resources that are available to employees who are non-disabled. The provision of job finding services must be evaluated at least once every six calendar months by the ISP team, to assess whether the service is assisting the participant with the outcome of finding community employment. If the service is not assisting the participant with this outcome, the ISP team must identify changes to the Supported Employment Service to realize this outcome or other service options to meet the participant's needs. The provision of job support services must be evaluated at least annually, as part of the ISP process, to determine whether the participant continues to require the current level of authorized services. The ISP must be updated, if necessary, to reflect the team's determination.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. Refer to the Provider Specification section below for criteria on provider requirements.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

When Supported Employment Services are provided alone or in conjunction with Prevocational, Transitional Work or Licensed Day Habilitation services, the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 40 hours (160 15-minute units) per participant per calendar week based on a 52-week year.

The direct portion of Supported Employment may not be provided at the same time as any of the following: Companion Services, Home and Community Habilitation, Licensed Day Habilitation, Prevocational Services and Transitional Work Services.

This service may not occur in a 55 Pa. Code Chapter 2390 (licensed prevocational) facility or setting.

Supported Employment Services may not be rendered under the Waiver until it has been verified that the services are not available to the participant under a program funded by either the Rehabilitation Act of 1973 as amended, or IDEA. Documentation must be maintained in the file of each participant receiving Supported Employment Services to satisfy the state assurance that the service is not otherwise available to the participant under a program funded under the Rehabilitation Act of 1973 as amended or IDEA.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment - Job Finding and Job Support

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Supported Employment Service.
Other Standard *(specify)*:
1.Be a legal resident of Pennsylvania or a state contiguous to Pennsylvania with supporting documentation (for SSWs).

2.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania (for an individual that is not a SSW).

3.Be 18 years of age.

4.Complete necessary pre/in-service training based on the ISP.

5.Agree to carry out the Supported Employment outcomes included in the ISP.

6.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

7.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Supported Employment Service.

8.Have a valid driver's license if the operation of a vehicle is necessary to provide Supported Employment Services.

9.Have Workers' Compensation Insurance in accordance with state statute or in accordance with ODP FMS policies.

10.Be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

11.Comply with Department standards related to provider qualifications.
Verification of Provider Qualifications
Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment - Job Finding and Job Support

Provider Category:
Agency
Provider Type:
Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Supported Employment Service.

Other Standard *(specify):*
Agencies must meet the following standards:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Supported Employment Service.

4.Have Workers' Compensation Insurance in accordance with state statute.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

6.Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies must meet the following standards:
1.Be 18 years of age.

2.Agree to carry out the Supported Employment outcomes included in the ISP.

3.Complete necessary pre/in-service training based on the ISP.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Have a valid driver's license if the operation of a vehicle is necessary to provide Supported Employment services.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee

Frequency of Verification:
At least every 2 years or more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Supports Coordination

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope)*:
Supports Coordination is a critical service that involves the primary functions of locating, coordinating, and monitoring needed services and supports for waiver participants (see requirements in Appendix D). Locating services and supports consists of assistance to the participant and his or her family in linking, arranging for, and obtaining services specified in an Individual Support Plan (ISP), including needed medical, social, habilitation, education, or other needed community services. Activities included under the locating function include all of the following, as well as the documentation of the activities:
•Participate in the ODP standardized needs assessment process to inform development of the ISP, including any necessary ISP updates;

•Facilitate the completion of additional assessments, based on participants' unique strengths and needs, for planning purposes and ISP development in order to address all areas of needs and the participant's strengths and preferences;

•Locate resources for the development of the ISP;

•Assist the participant in identifying people to serve as part of the ISP team, and offer support to invite other people who may contribute valuable information during the planning process;

•Assist the participant and his or her family in identifying and choosing willing and qualified providers;

•Inform participants about the use of unpaid, informal, generic, and specialized services and supports that are necessary to address the identified needs of the participant and to achieve the outcomes specified in the ISP;

•Provide information to participants on fair hearing rights and assist with fair hearing requests when needed and upon request; and

• Assist participants in gaining access to needed services and to exercise their civil rights.

Coordinating consists of development and ongoing management of the ISP in cooperation with the participant, his or her family, members of the ISP team, and providers of service. Activities included under the coordinating function include all of the following, as well as the documentation of the activities:
•Use a person centered planning approach and a team process to develop the participant's ISP to meet the participant's needs in the least restrictive manner possible;

•Use information from the ODP standardized needs assessment, as well as any additional assessments completed based on the unique needs of the participant, to develop the ISP to address all of the participant's needs;

•Periodic review of the ISP with the participant, including update of the ISP at least annually and whenever a participant's needs change;

•Periodic review of the standardized needs assessment through a face-to-face visit with the participant, at least annually or more frequently based on changes in a participant's needs, to ensure the assessment is current;

•Coordinate ISP planning with providers of service to ensure consistency of services;

•Coordinate with other entities, resources and programs as necessary to ensure all areas of the participant's needs are addressed;

•Contact with family, friends, and other community members to facilitate coordination of the participant's natural support network;

•Facilitate the resolution of barriers to service delivery; and

•Disseminate information and support to participants and others who are responsible for planning and implementation of services.

Monitoring consists of ongoing contact with the participant and his or her family, to ensure services are implemented as per the ISP. Activities included under the monitoring function include all of the following, as well as the documentation of the activities:
•Monitor the health and welfare of participants through regular contacts at the minimum frequency outlined inAppendix D-2-a of this Waiver;

•Monitor ISP implementation through monitoring visits with the participant, at the minimum frequency outlined in Appendix D-2-a of this Waiver;

•Visit with the participant's family, when applicable, and providers of service for monitoring of health and welfare and ISP implementation;

•Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health and welfare of participants;

•Review participant progress on outcomes and initiate ISP team discussions or meetings when services are not achieving desired outcomes;

•Monitor participant and/or family satisfaction with services;

•Arrange for modifications in services and service delivery, as necessary to address the needs of the participant, and modify the ISP accordingly;

•Ensure that services are identified in the ISP;

•Work with the authorizing entity regarding the authorization of services on an ongoing basis and when issues are identified regarding requested services;

•Communicate the authorization status to ISP team members, as appropriate;

•Validate that service objectives and outcomes are consistent with the participant's needs and desired outcomes;

•Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and participant rights; and

•Participate in activities related to Independent Monitoring for Quality, such as obtaining consent to participate from the participant, preparing survey information, and follow up activities ("closing the loop") and other activities as identified by ODP.

In addition to locating, coordinating, and monitoring, Supports Coordination also includes providing information and assistance in order to help participants transition to the community or, in accordance with Appendix E, decide whether to select participant direction of services, and assistance for participants who opt to direct services. Activities include all of the following, in addition to the documentation of activities:
•Provide participants with information on participant direction, including the potential benefits and risks associated with directing services, during the planning process and upon request;

•Assist with the transition to the participant direction service delivery model if the participant is interested in this model, and ensure continuity of services during transition;

•Assist the participant in designating a surrogate, as desired, as outlined in Appendix E-1-f of this Waiver; and

•Provide participants with the standard ODP information about participant direction, an explanation of the options and the contact information for the Financial Management Services provider.

The following activities are excluded from Supports Coordination as a billable Waiver service:
•Outreach that occurs before an individual is enrolled in the Waiver;

•Intake for purposes of determining whether an individual has an intellectual disability and qualifies for Medical Assistance;

•Direct Prevention Services, which are used to reduce the probability of the occurrence of an intellectual disability resulting from social, emotional, intellectual, or biological disorders;
• General information to participants, families, and the public that is not on behalf of a waiver participant, such as school fairs;

•Travel time incurred by the Supports Coordinator may not be billed as a discrete unit of service;

•Services otherwise available under the MA State Plan and other programs;

•Services that constitute the administration of foster care programs;

•Services that constitute the administration of another non-medical program such as child welfare or child protective services, parole and probation functions, legal services, public guardianship, and special education;

•Direct delivery of medical, educational, social, or other services;

•Delivery of medical treatment and other specialized services including physical or psychological examinations or evaluations;

•The actual cost of the direct services other than Supports Coordination that the Supports Coordinator links, arranges, or obtains on behalf of the participant;

•Transportation provided to participants to gain access to medical appointments or direct Waiver services other than Supports Coordination;

•Representative payee functions;

•Conducting Medicaid eligibility certification or recertification, intake processing, Medicaid pre-admission screening for inpatient care, prior authorization for Medicaid services, and Medicaid outreach (methods to inform or persuade individuals to enter into care through the Medicaid system); and

•Assistance in locating and/or coordinating burial or other services for a deceased participant.

During temporary travel Supports Coordination may be provided in Pennsylvania or other locations as per the ODP travel policy. Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Supports Coordination services may not duplicate other direct Waiver services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supports Coordination Organization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supports Coordination

Provider Category:
Agency
Provider Type:
Supports Coordination Organization
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Supports Coordination Service.
Other Standard *(specify)*:
Minimum Qualifications of SCOs:
1.Have a waiver service location in Pennsylvania.

2.Comply with and meet all standards as applied through each phase of the standard, annual ODP-performed SCO monitoring process.

3.Function as a conflict free entity. A conflict-free SCO, for purposes of this service definition, is an independent, separate, or self-contained agency. To be conflict free, an SCO may not provide direct or indirect services to participants. The following are considered direct and indirect services:

Direct Services:
-All intellectual disability services provided to base-funded individuals and waiver participants with the exception of Waiver Supports Coordination, Targeted Service Management and State-funded Case Management as well as transportation and ICF/ID services where the SCO shares a Federal Employer Identification Number (FEIN) with the provider.

Indirect Services:
-All services related to Health Care Quality Units, Independent Monitoring Teams, Organized Health Delivery System Providers, Financial Management Service Providers/Organizations for Waiver participants, and the Statewide Needs Assessment with the exception of Family Driven Support Service funds and the administration of Money Follows the Person (MFP) as approved by CMS.

4.Have their Board composed of a maximum of 49% of members who have a business or fiduciary relationship with a direct provider of Consolidated, P/FDS, or ID Base Services other than Supports Coordination or Targeted Service Management.

5.Ensure 24-hour access to SCO personnel (via direct employees or a contract) for response to emergency situations that are related to the supports coordination service or other waiver services.

6.Conduct a standard ODP customer satisfaction survey with a representative sample of participants as specified by ODP and take corrective action based on results.

7.Have an agreement with the local intake entity to ensure consistent referrals of eligible individuals and a smooth transition to the SCO, unless this function is provided by a unit of the SCO as a non-covered service.

8.Meet the requirements for operating a not-for-profit, profit, or governmental organization in Pennsylvania.

9.Have Commercial General Liability Insurance or provide evidence of self insurance as specified by insurance standards.

10.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Supports Coordination Service.

11.Have Workers' Compensation Insurance in accordance with state statute.

12.Have a written procedure for utilizing the Home and Community Services Information System (HCSIS) to document and perform Supports Coordination activities.

13.Have a written procedure for the reconciliation of claims, the management of denied claims and the rebilling of denied claims.

14.Comply with HIPAA which includes having a written procedure that outlines requirements.

15.Cooperate with monitoring conducted by ODP or its designee.

16.Cooperate with and assist, as needed, ODP and any state and federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting Medicaid fraud and abuse.

17.Have a written procedure to review the utilization of Supports Coordination Services.

18.Have a Quality Management plan consistent with ODP's Quality Management Plan and strategy in the approved Waiver.

19.Agree to immediately notify ODP in writing of any noncompliance or failure to meet any of these qualification criteria.

20.Cooperate with Health Care Quality Units, independent monitoring teams, and other external monitoring conducted by ODP's designees.

21.Agree to commit to transition planning in the event of termination by the SCO or termination of qualification by ODP.

22.Comply with Department standards related to provider qualifications.

Minimum Qualifications for Supports Coordinators and Supports Coordinator Supervisors who have a caseload and provide services through a SCO:
1.Newly hired Supports Coordinators receive ODP required orientation.

2.Receive a minimum of 40 hours of training each calendar year, comprised of the required annual ODP sponsored training sessions and local training.

3.Supports Coordinator Supervisors without a caseload receive the required annual ODP sponsored training.

4.Have a valid driver's license if the operation of a vehicle is necessary to provide Supports Coordination Services.

5.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

6.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

7.Meet the following minimum educational and experience requirements:
-A bachelor's degree, which includes or is supplemented by at least 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social science; or

-Two years experience as a County Social Service Aide 3* and two years of college level course work, which include at least 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social service; or

-Any equivalent combination of experience and training which includes 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social service and one year of experience as a County Social Services Aide 3 or similar position performing paraprofessional case management functions.
*The nature of the work and job requirements for County Social Service Aide 3 positions can be found at www.scsc.state.pa.us

8.Comply with Department standards related to provider qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP
Frequency of Verification:
At least annually and more frequently as deemed necessary by ODP.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Nursing

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
49 Pa. Code Chapter 21 (State Board of Nursing) provides the following service definition for the practice of professional nursing:

"Diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The term does not include acts of medical diagnosis or prescription of medical, therapeutic or corrective measures, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the Board, which rules and

regulations will be implemented by the Board."

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania.
During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Nursing Services may only be funded through the Waiver if there is documentation that the service is medically necessary and not covered through the Medical Assistance (MA) State Plan which includes Early Periodic Screening and Diagnostic Testing (EPSDT), Medicare and/or private insurance. Nursing Services must be provided under the MA State Plan including EPSDT, Medicare and/or private insurance plans until the plan limitations have been reached and documentation is secured by the Supports Coordinator.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Agency
Individual	Nurse

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nursing

Provider Category:
Agency
Provider Type:
Nursing Agency
Provider Qualifications
License *(specify)*:
Employees (direct, contracted, or in a consulting capacity) providing Nursing Services must be a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

Providers with a waiver service location in Pennsylvania must comply with Title 49 Pa. Code Chapter 21.

Providers with a waiver service location in a state contiguous to Pennsylvania must comply with regulations comparable to Title 49 Pa. Code Chapter 21.
Certificate *(specify)*:

Other Standard *(specify)*:
Agencies must meet the following standards:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have Workers' Compensation Insurance, in accordance with state statute.

4.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

5.Comply with Department standards related to provider qualifications.

Nurses working for or contracting with agencies must meet the following standards:
1.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

2.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

3.Agree to carry out the Nursing outcomes included in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nursing

Provider Category:

Individual

Provider Type:

Nurse

Provider Qualifications

License *(specify):*

Must be a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

Must comply with Title 49 Pa. Code Chapter 21.

Providers with a waiver service location in a state contiguous to Pennsylvania must comply with regulations comparable to Title 49 Pa. Code Chapter 21.

Certificate *(specify):*

Other Standard *(specify):*

1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

4.Have Workers' Compensation Insurance, in accordance with state statute.

5.Agree to carry out the Nursing outcomes included in the ISP.

6.Be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

7.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Therapy Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Therapy services include the following:
•Physical therapy provided by a licensed physical therapist based on a prescription for a specific therapy program by a physician.

•Occupational therapy by a registered occupational therapist based on a prescription for a specific therapy program by a physician.

•Speech/language therapy provided by an American Speech-Language-Hearing Association (ASHA) certified and state licensed speech-language pathologist. This service requires an evaluation and recommendation by an ASHA certified and state licensed speech-language pathologist or a physician.

•Visual/mobility therapy provided by a trained visual or mobility specialist/instructor based on an evaluation and recommendation by a trained mobility specialist/instructor or a physician.

•Behavior therapy provided by a licensed psychologist or psychiatrist based on an evaluation and recommendation by a licensed psychologist or psychiatrist.

Therapy services are direct services provided to assist participants in the acquisition, retention, or improvement of skills necessary for the participant to live and work in the community, and must be attached to a participant's outcome as documented in his or her ISP. Training caretakers and development of a home program for caretakers to implement the recommendations of the therapist are included in the provision of Therapy services. The need for the service must be documented by a professional as noted above for each service and must be evaluated at least annually, or more frequently if needed, as part of the ISP process. This evaluation must review

whether the participant continues to require the current level of authorized services and that the service continues to result in positive outcomes for the participant. It is recognized, however, that long-term Therapy services may be necessary due to a participant's extraordinary medical or behavioral conditions. The need for long-term Therapy services must be documented in the participant's ISP.

Physical Therapy: The Physical Therapy Practice Act (63 P.S. §1301 et seq.) defines physical therapy as follows: "…means the evaluation and treatment of any person by the utilization of the effective properties of physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and rehabilitative procedures including training in functional activities, with or without assistive devices, for the purpose of limiting or preventing disability and alleviating or correcting any physical or mental conditions, and the performance of tests and measurements as an aid in diagnosis or evaluation of function."

Occupational Therapy: The Occupational Therapy Practice Act (63 P.S. §1501 et seq.) defines occupational therapy as follows: "The evaluation of learning and performance skills and the analysis, selection and adaptation of activities for an individual whose abilities to cope with the activities of daily living, to perform tasks normally performed at a given stage of development and to perform essential vocational tasks which are threatened or impaired by that person's developmental deficiencies, aging process, environmental deprivation or physical, psychological, injury or illness, through specific techniques which include: (1) Planning and implementing activity programs to improve sensory and motor functioning at the level of performance for the individual's stage of development; (2) Teaching skills, behaviors and attitudes crucial to the individual's independent, productive and satisfying social functioning; (3) The design, fabrication and application of splints, not to include prosthetic or orthotic devices, and the adaptation of equipment necessary to assist patients in adjusting to a potential or actual impairment and instructing in the use of such devices and equipment; and (4) Analyzing, selecting and adapting activities to maintain the individual's optimal performance of tasks to prevent disability."

Speech and Language Therapy: Services provided by a licensed and American Speech-Language-Hearing Association (ASHA) certified speech-language pathologist including the evaluation, counseling, habilitation and rehabilitation of participants whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification, examination, diagnosis and treatment of conditions of the human speech-language system, and including the examination for, and adapting and use of augmentative and alternative communication strategies, including, assistive devices and assistive technology.

Behavior Therapy: The treatment, by psychological means, of the problem of an emotional nature in which a licensed psychologist or psychiatrist deliberately establishes a professional relationship with a participant, in an attempt to alleviate or ameliorate the emotional distress disturbances, reverse or change maladaptive patterns of behavioral challenges, and promote positive personality growth and development. Such therapy must take place at the psychologist or psychiatrist's office and may take the form of either individual therapy with the participant and the psychologist or psychiatrist, or group therapy with the participant and other individuals receiving therapy that is supervised and directed by the psychologist or psychiatrist.

Visual/Mobility Therapy: This therapy is for participants who are blind or have visual impairments. The provision of therapy is for the purpose of increasing participants' travel skills and/or access to items used in activities of daily living. This service may include evaluation and assessment of participants and the environments in which they interact, direct service (face-to-face) to participants, and training of support individuals. The provision of this service may result in recommendations for adapting environments or purchasing assistive technology.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Therapy Services may only be funded through the Waiver if there is documentation that the service is medically necessary and not covered through the MA State Plan which includes EPSDT, Medicare and/or private insurance. Therapy Services must be provided under the MA State Plan including EPSDT, Medicare and/or private insurance plans until the plan limitations have been reached and documentation is secured by the Supports Coordinator.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Speech/Language Therapy Agency
Individual	Speech/Language Therapist
Agency	Behavior Therapy Agency
Individual	Behavior Therapist
Agency	Physical Therapy Agency
Individual	Physical Therapist
Agency	Occupational Therapy Agency
Individual	Occupational Therapist
Agency	Visual/Mobility Therapy Agency
Individual	Visual/Mobility Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Therapy Services

Provider Category:

Agency

Provider Type:

Speech/Language Therapy Agency

Provider Qualifications

License *(specify)*:

Employees (direct, contracted, or in a consulting capacity) providing Speech/Language Therapy must be licensed as speech-language pathologists.

Certificate *(specify)*:

Employees (direct, contracted, or in a consulting capacity) providing Speech/Language Therapy must be ASHA certified.

Other Standard *(specify)*:

Agencies must meet the following standards:

1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have Workers' Compensation Insurance, in accordance with state statute.

4.Comply with Department standards related to provider qualifications.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

Therapists working for or contracted with agencies must meet the following standards:

1.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

2.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

3.Agree to carry out the Speech/Language Therapy outcomes included in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Therapy Services

Provider Category:

Individual

Provider Type:

Speech/Language Therapist

Provider Qualifications

License *(specify):*

Must be a state licensed speech-language pathologist.

Certificate *(specify):*

Must be ASHA certified.

Other Standard *(specify):*

1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

4.Agree to carry out the Speech/Language Therapy outcomes included in the ISP.

5.Have Workers' Compensation Insurance, in accordance with state statute.

6.Have training to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

7.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Therapy Services

Provider Category:

Agency

Provider Type:

Behavior Therapy Agency

Provider Qualifications

License *(specify):*

Employees (direct, contracted, or in a consulting capacity) providing Behavior Therapy Services must

be licensed Psychologists or licensed Psychiatrists.
Certificate *(specify):*

Other Standard *(specify):*
Agencies must meet the following standards:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have Workers' Compensation Insurance, in accordance with state statute.

4.Comply with Department standards related to provider qualifications.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

Therapists working for or contracted with agencies must meet the following standards:
1.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

2.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

3.Agree to carry out the Behavior Therapy outcomes included in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Therapy Services

Provider Category:
Individual
Provider Type:
Behavior Therapist
Provider Qualifications

License *(specify):*
Must be a licensed Psychologist or a licensed Psychiatrist.
Certificate *(specify):*

Other Standard *(specify):*
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

4.Agree to carry out the Behavior Therapy outcomes included in the ISP.

5.Have Workers' Compensation Insurance, in accordance with state statute.

6.Have training to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

7.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Therapy Services

Provider Category:

Agency

Provider Type:

Physical Therapy Agency

Provider Qualifications

License *(specify):*

Employees (direct, contracted, or in a consulting capacity) providing Physical Therapy must be licensed as Physical Therapists.

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have Workers' Compensation Insurance, in accordance with state statute.

4.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

5.Comply with Department standards related to provider qualifications.

Therapists working for or contracted with agencies must meet the following standards:

1.Meet the licensing requirements specified in 'License' above.

2.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

4.Agree to carry out the Physical Therapy outcomes included in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

Service Type: Extended State Plan Service
Service Name: Therapy Services

Provider Category:
Individual
Provider Type:
Physical Therapist
Provider Qualifications
License *(specify):*
Must be a licensed Physical Therapist.
Certificate *(specify):*

Other Standard *(specify):*
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

4.Agree to carry out the Physical Therapy outcomes included in the ISP.

5.Have Workers' Compensation Insurance, in accordance with state statute.

6.Have training to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

7.Comply with Department standards related to provider qualifications.
Verification of Provider Qualifications
Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Therapy Services

Provider Category:
Agency
Provider Type:
Occupational Therapy Agency
Provider Qualifications
License *(specify):*
Employees (direct, contracted, or in a consulting capacity) providing Occupational Therapy must be licensed as Occupational Therapists.
Certificate *(specify):*

Other Standard *(specify):*
Agencies must meet the following standards:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have Workers' Compensation Insurance, in accordance with state statute.

4.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

5.Comply with Department standards related to provider qualifications.

Therapists working for or contracted with agencies must meet the following standards:
1.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

2.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

3.Agree to carry out the Occupational Therapy outcomes included in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Therapy Services

Provider Category:
Individual
Provider Type:
Occupational Therapist
Provider Qualifications

License *(specify):*
Must be a licensed Occupational Therapist.
Certificate *(specify):*

Other Standard *(specify):*
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

4.Agree to carry out the Occupational Therapy outcomes included in the ISP.

5.Have Workers' Compensation Insurance, in accordance with state statute.

6.Have training to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

7.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Therapy Services

Provider Category:
Agency
Provider Type:
Visual/Mobility Therapy Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Employees (direct, contracted, or in a consulting capacity) providing Visual/Mobility Therapy must be trained visual or mobility specialists/instructors.
Other Standard *(specify):*
Agencies must meet the following standards:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have Workers' Compensation Insurance, in accordance with state statute.

4.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

5.Comply with Department standards related to provider qualifications.

Therapists working for or contracted with agencies must meet the following standards:
1.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

2.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

3.Agree to carry out the Visual/Mobility Therapy outcomes included in the ISP.
Verification of Provider Qualifications
Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every two years and more frequently as deemed necessary by ODP.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Therapy Services

Provider Category:
Individual
Provider Type:
Visual/Mobility Therapist
Provider Qualifications

License *(specify):*

Certificate *(specify):*
Must be a trained visual or mobility specialist/instructor.
Other Standard *(specify):*
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

4.Agree to carry out the Visual/Mobility Therapy outcomes included in the ISP.

5.Have Workers' Compensation Insurance, in accordance with state statute.

6.Have training to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

7.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Supports for Participant Direction
The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
Support for Participant Direction:
Information and Assistance in Support of Participant Direction
Alternate Service Title (if any):
Supports Broker Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
The Supports Broker service is available to participants who elect to self-direct their own services utilizing one of the participant directed options outlined in Appendix E-1 of the Waiver. The Supports Broker service is designed to assist participants or their designated surrogate with employer-related functions in order to be successful in self-directing some or all of the participants needed services.

This service is limited to the following list of activities:
•Explaining and providing support in completing employer-or managing employer related paperwork.

•Participating in Financial Management Services (FMS) orientation and other necessary trainings and interactions with the FMS provider.

•Developing effective recruiting and hiring techniques.

•Determining pay rates for workers.

•Providing or arranging for worker training.

•Developing worker schedules.

•Developing, implementing and modifying a back-up plan for services, staffing for emergencies and/or worker absences.

•Scheduling paid and unpaid supports.

•Developing effective management and supervision techniques such as conflict resolution.

•Developing proper procedures for termination of workers in the VF/EA FMS option or communication with the Agency With Choice regarding the desire for removal of the workers from working with the participant in the AWC FMS option.

•Reviewing of workplace safety issues and strategies for effective management of workplace injury prevention.

•Assisting the participant or their designated surrogate in understanding and/or fulfilling the responsibilities outlined in the Common Law Employer Agreement form and the Managing Employer Agreement form.

•Facilitating a support group that helps to meet the participant's self-direction needs. These support groups are separate and apart from the ISP team meetings arranged and facilitated by the Supports Coordinator.

•Expanding and coordinating informal, unpaid resources and networks within the community to support success with participant direction.

•Identifying areas of support that will promote success with self-direction and independence and share the information with the team and Supports Coordinator for inclusion in the ISPs.

•Identifying and communicating any proposed modifications to the participant's ISP.

•Advising and assisting with the development of procedures to monitor expenditures and utilization of services.

•Complying with the standards, regulations, policies and the waiver requirements related to self-direction.

•Advising in problem-solving, decision-making, and achieving desired personal and assessed outcomes related to the participant directed services.

•When applicable, securing a new surrogate and responding to notices for corrective action from the FMS, SC, AE or ODP.

•All functions performed by a Supports Broker must be related to the personal and assessed outcomes related to the participant directed services in the ISP.

Supports Brokers must work collaboratively with the participant's Supports Coordinator and team. Supports Brokers may not replace the role of, or perform the functions of a Supports Coordinator. The role of the Supports Coordinator continues to involve providing the primary functions of locating, coordinating, and monitoring of waiver services; while the Supports Broker assists participants or their designated surrogate with assistance with the above noted functions. No duplicate payments will be made.

Supports Broker Services may be provided by individual and agency providers that provide other Waiver or ID services but the Supports Broker provider must be conflict free. In order to be conflict free, the Supports Broker provider may not provide other direct or indirect waiver services or base funded ID services when authorized to provide Support Broker services to the waiver participant. In addition, Supports Broker providers may not provide administrative services such as Health Care Quality Unit, Administrative Entity functions or Independent Monitoring Program.

The AWC FMS providers are in a unique circumstance in that they are required to provide the AWC FMS administrative services in addition to all identified participant directed waiver services authorized for a participant who is self-directing and enrolled with the AWC FMS provider. As such, the AWC FMS provider will be able to provide both supports broker services and other participant directed waiver services to the same participant but only as an AWC FMS Provider Type (PT) 54.

The VF/EA FMS is required to provide the VF/EA FMS administrative service and pay for all identified participant directed services authorized for a participant who is self-directing and enrolled with the VF/EA FMS as a PT 54.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is limited to a maximum of 1040 (15-minute) units per participant per fiscal year based on a 52-week year. This service is limited to participants who are self-directing their services through an AWC or VF/EA FMS.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Supports Broker
Agency	Supports Brokerage Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Supports Broker Services

Provider Category:
Individual
Provider Type:

Supports Broker
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Supports Broker Service.
Other Standard *(specify):*
1.Be a legal resident of Pennsylvania or a state contiguous to Pennsylvania with supporting documentation (for SSWs).

2.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania (for an individual that is not a SSW).

3.Be at least 18 years of age.

4.Complete necessary pre/in-service training based on the participant's ISP.

5.Agree to carry out the Supports Broker responsibilities based on the ISP.

6.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

7.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

8.Have automobile insurance for all vehicles owned, leased, and/or hired and used as a component of the Supports Broker Service.

9.Have a valid driver's license if the operation of a vehicle is necessary to provide Supports Broker Services.

10.Have Workers' Compensation Insurance, in accordance with state statute or in accordance with ODP FMS policies.

11.Have received training in basic employment law, have one year of experience working in human resources, have one year of experience in a management position with human resource responsibilities, or have a degree in human resources.

12.Have received training on the principles of self-determination.

13.Have received training on participant directed services.

14.Have received training on person centered thinking if assisting in planning meetings.

15.Be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

16.Comply with Department standards related to provider qualifications.
Verification of Provider Qualifications
Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Supports Broker Services

Provider Category:
Agency
Provider Type:
Supports Brokerage Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Supports Broker Service.
Other Standard *(specify)*:
The Supports Broker agency must meet the following requirements:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have auto insurance for all vehicles owned, leased, and/or hired and used as a component of the Supports Broker Service.

3.Have Workers Compensation Insurance, in accordance with state statute.

4.Have Commercial General Liability Insurance.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

6.Comply with Department standards related to provider qualifications.

Supports brokers working for or contracting with the agency must meet the following requirements:
1.Be at least 18 years of age.

2.Complete necessary pre/in-service training based on the ISP.

3.Agree to carry out the Supports Broker responsibilities based on the ISP.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Meet the following minimum requirements:
-Be trained in basic employment law;

-Have one year of experience in a management position with human resource responsibilities; OR

-Have a degree in human resources.

7.Be trained on the principles of self-determination.

8.Be trained on participant directed services.

9.If assisting in planning meetings, be trained on person centered thinking.

10.Be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

11.Have a valid driver's license if the operation of a vehicle is necessary to provide Supports Broker services.
Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Assistive Technology

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
An item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve a participant's functioning. Assistive technology services include direct support to a participant in the selection, acquisition, or use of an assistive technology device, limited to:
•Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the participant;

•Selecting, fitting, customizing, adapting, maintaining, repairing, or replacing assistive technology devices;

• Training for the participant, or where appropriate, the participant's family members, guardian, advocate, staff, or authorized representative on how to use and/or care for the assistive technology;

• Extended warranties; and

• Ancillary supplies, software, and equipment necessary for the proper functioning of assistive technology devices, such as replacement batteries and materials necessary to adapt low-tech devices. This includes applications for electronic devices not available through the Waiver that assist participants with a need identified through the evaluation described below.

All items shall meet the applicable standards of manufacture, design, and installation. Items shall be specific to

the participant's needs and not be a device or equipment that benefits the public at large, staff, significant others, or family members. Although Waiver funds cannot be used to purchase items such as iPads, iPods or personal computers, applications to such items that assist participants with a need identified through the evaluation described below are eligible for Waiver funding through this service. Items reimbursed with Waiver funds shall be in addition to any medical supplies provided under the MA State Plan and shall exclude those items not of direct medical or remedial benefit to the participant. If the participant receives Behavioral Therapy or Behavioral Support Services, the assistive technology must be consistent with the participant's behavior support plan.

Assistive technology devices must be recommended by an independent evaluation of the participant's assistive technology needs. The organization or professional providing the evaluation shall be credentialed, licensed, or certified in an area related to the specific type of technology needed, and may not have a fiduciary relationship with the assistive technology provider.

Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Assistive technology may only be funded through the Waiver if there is documentation that the service is medically necessary and not covered through the MA State Plan which includes EPSDT, Medicare and/or private insurance. Assistive Technology must be provided under the MA State Plan including EPSDT, Medicare and/or private insurance plans until the plan limitations have been reached and documentation is secured by the Supports Coordinator. Assistive technology has a lifetime limit of $10,000.00 per participant except when the limit is extended by ODP using the standard ODP exception process.

Durable medical equipment, as defined by 55 Pa. Code Chapter 1123 and the MA State Plan, is excluded.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania. (A company

that the provider secures the item(s) from can be located anywhere.)

2.Adhere to all applicable local and state codes.

3.Have Commercial General Liability Insurance.

4.Have Workers Compensation Insurance, in accordance with state statute.

5.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Support

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

This is a service that includes functional assessment; the development of strategies to support the participant based upon assessment; and the provision of training to participants, staff, parents and caregivers. Services must be required to meet the current needs of the participant, as documented and authorized in the ISP.

The service is performed by an individual with a Masters Degree in Human Services (or a closely related field) or an individual under the supervision of a professional who is licensed or has a Masters Degree in Human Services (or a closely related field), and is limited to the following:

•Collection and evaluation of behavioral data;

•Observation of the participant in various settings for the purpose of developing a behavior support plan;

•Collaboration with the participant, their family, and their team for the purpose of developing a behavior support plan that must include positive practices and may not include restraint procedures (physical, chemical, or mechanical) as support strategies;

•Conducting comprehensive functional assessments of presenting issues (e.g. aggression, self-injurious behavior, law offending behavior [sexual or otherwise]);

•Development and maintenance of behavior support plans, which utilize positive strategies to support the participant, based on functional behavioral assessments;

•Conducting training related to the implementation of behavior support plans for the participant, family members, staff and caretakers;

•Implementation of activities and strategies identified in the participant's behavior support plan;

•Monitoring implementation of the behavior support plan, and revising as needed;

•Collaboration with the participant, their family, and their team in order to develop positive interventions to address specific presenting issues; and

•Completion of required paperwork related to data collection, progress reporting and development of annual planning material.

Services may be provided in the office of the Behavioral Support professional, the participant's home or service location, or in local public community environments necessary for the provision of the Behavioral Support Services. Direct services must be provided on a one-on-one basis.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Behavioral Support services may be provided during the same day and time as other Waiver services, but may not duplicate other Waiver services.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Behavior Support Agency
Individual	Behavior Support Specialist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support

Provider Category:
Agency

Provider Type:
Behavior Support Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Employees (direct, contracted, or in a consulting capacity) providing Behavioral Support Services must have a Masters Degree in Human Services (or a closely related field) or work under the supervision of a professional who has a Masters Degree in Human Services (or a closely related field).

Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Behavioral Support Service.
Other Standard *(specify):*
The Behavioral Support agency must meet the following requirements:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have auto insurance for all vehicles owned, leased, and/or hired and used as a component of the Behavioral Support Service.

3.Have Workers' Compensation Insurance, in accordance with state statute.

4.Have Commercial General Liability Insurance.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

6.Comply with Department standards related to provider qualifications.

Behavior Support Specialist staff working for the agency must meet the following requirements:
1.Be at least 18 years of age.

2.Complete necessary pre/in-service training based on the participant's ISP.

3.Agree to carry out the Behavioral Support Service outcomes included in the ISP.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Complete training in conducting and using a Functional Behavioral Assessment.

7.Complete training in positive behavioral support.

8.Have at least 2 years experience in working with people with intellectual disabilities.

9.Have a valid driver's license if the operation of a vehicle is necessary to provide Behavioral Support Service.
Verification of Provider Qualifications
Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support

Provider Category:
Individual
Provider Type:
Behavior Support Specialist
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Must have a Masters Degree in Human Services (or a closely related field) or work under the supervision of a professional who has a Masters Degree in Human Services (or a closely related field).

Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Behavioral Support Service.
Other Standard *(specify):*
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Be at least 18 years of age.

3.Complete necessary pre/in-service training based on the participant's ISP.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have Child Abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Have auto insurance for all vehicles owned, leased, and/or hired and used as a component of the Behavioral Support Service.

7.Have a valid driver's license if the operation of a vehicle is necessary to provide Behavioral Support Services.

8.Be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

9.Have Workers' Compensation Insurance, in accordance with state statute.

10.Complete training in conducting and using a Functional Behavioral Assessment.

11.Complete training in positive behavioral support.

12.Have at least 2 years experience in working with people with intellectual disabilities.

13.Agree to carry out the Behavioral Support outcomes included in the ISP.

14.Comply with Department standards related to provider qualifications.
Verification of Provider Qualifications
Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Companion

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Companion services are provided to participants living in private homes for the limited purposes of providing supervision and assistance that is focused solely on the health and safety of the adult participant with intellectual disabilities. This service is not available to participants who are residing in Unlicensed or Licensed Residential Habilitation settings. Companion Services are used in lieu of Home and Community Habilitation Services to protect the health and welfare of the participant when a habilitative outcome is not appropriate or feasible (i.e. when the participant is not learning, enhancing, or maintaining a skill). This service can be used for asleep hours when only supervision or non-medical or non-habilitative care is needed to protect the safety of the participant with intellectual disabilities. For example, a companion can be used during overnight hours for a participant who lives on their own but does not have the ability to safely evacuate in the event of an emergency.

This service can also be used to supervise participants during socialization or non-habilitative activities when necessary to ensure the participant's safety. Companions may supervise and provide assistance with daily living activities, including grooming, health care, household care, meal preparation and planning, and socialization. This service may not be provided at the same time as any other direct service (with the exception of Supports Coordination). When services are provided by agency-based providers, this service also includes transportation services necessary to enable the participant to participate in the Companion Service, in accordance with the participant's ISP. This service is not available to participants when a legally responsible person is required to provide supervision or assistance or when the service is a covered service under the MA State Plan.

This service may be provided at the following levels:

•Basic Staff Support - The provision of the service at a staff-to-individual ratio of no less than 1:6.

•Level 1 - The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.

•Level 2 - The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.

•Level 3 - The provision of the service at a staff-to-individual ratio of 1:1.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. Refer to the

Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Companion Services are not available for participants residing in agency-owned, rented/leased, or operated homes. This service may not be provided at the same time as any other direct waiver service (with the exception of Supports Coordination).

Companion Services and Home and Community Habilitation have a maximum limit of 24 hours (96 15-minute units) per participant per calendar day whether used in combination or alone.

Companion Services may not be provided at the same time as any of the following: Home and Community Habilitation, the direct portion of Supported Employment, Licensed Day Habilitation, Prevocational Services and Transitional Work Services.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Companion
Agency	Companion Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion

Provider Category:
Individual

Provider Type:
Individual Companion

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Companion Service.

Other Standard *(specify)*:
1.Be a legal resident of Pennsylvania or a state contiguous to Pennsylvania with supporting documentation (for SSWs).

2.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania (for an individual that is not a SSW).

3.Be at least 18 years of age.

4.Complete necessary pre/in-service training based on the ISP.

5.Agree to carry out the Companion outcomes included in the ISP.

6.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

7.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

8.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Companion Service.

9.Have a valid driver's license if the operation of a vehicle is necessary to provide Companion Services.

10.Have Workers' Compensation Insurance, in accordance with state statute or in accordance with ODP FMS policies.

11.Be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

12.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion

Provider Category:

Agency

Provider Type:

Companion Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Companion Service.

Other Standard *(specify)*:

Agencies must meet the following standards:

1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Companion Service.

4.Have Workers' Compensation Insurance, in accordance with state statute.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

6.Comply with Department standards related to provider qualifications.

Staff working for or contracted with the agency must meet the following standards:
1.Be at least 18 years of age.

2.Complete necessary pre/in-service training based on the ISP.

3.Agree to carry out the Companion outcomes included in the ISP.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Have a valid driver's license if the operation of a vehicle is necessary to provide Companion Services.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home Accessibility Adaptations

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Home accessibility adaptations consist of certain modifications to the private home of the participant (including homes owned or leased by parents/relatives with whom the participant resides and family living homes that are privately owned, rented, or leased by the host family) which are necessary due to the participant's disability, to ensure the health, security of, and accessibility for the participant, or which enable the participant to function with greater independence in the home. This service may only be used to adapt the participant's primary

residence, may not be furnished to adapt homes that are owned, rented, leased, or operated by providers except when there is a needed adaptation for participants residing in a Family Living setting and the life sharing host home is owned, rented or leased by the host and not the Family Living Provider Agency.

Home modifications must have utility primarily for the participant with the disability, be an item of modification that the family would not be expected to provide to a family member without a disability, be an item that is not part of general maintenance of the home, and be an item or modification that is not part of room and board costs as defined in 55 Pa. Code Chapter 6200. Home modifications consist of installation, repair, maintenance, and extended warranties for the modifications; and when necessary to comply with rental/lease agreements, return of the property to its original condition. Adaptations that add to the total square footage of the home are excluded from this benefit. The only exception to this is adaptations to existing bathrooms that are necessary to complete the adaptation (e.g., necessary to configure a bathroom to accommodate a wheelchair).

All modifications shall meet the applicable standards of manufacture, design, and installation. Modifications shall be specific to the participant's needs and not be approved to benefit the public at large, staff, significant others, or family members; modifications or improvements to the home that are of general utility are excluded. Modifications not of direct medical or remedial benefit to the participant are excluded.

Modifications to a household subject to funding under the Waivers are limited to the following:
•Ramps from street, sidewalk or house.

•Vertical lifts.

•Portable or track lift systems. A portable lift system is a standing structure that can be wheeled around. A track lift system involves the installation of a "track" in the ceiling for moving an individual with a disability from one location to another.

•Handrails and grab-bars in and around the home.

•Accessible alerting systems for smoke/fire/CO2 for individuals with sensory impairments.

•Electronic systems that enable someone with limited mobility to control various appliances, lights, telephone, doors, and security systems in their room, home or other surroundings.

•Outside railing from street to home.

•Widened doorways, landings, and hallways.

•An additional doorway needed to ensure the safe egress of the participant during emergencies, when approved by the ODP Regional Office.

•Swing clear and expandable offset door hinges.

•Flush entries and leveled thresholds.

•Plexiglas windows for participants with behavioral issues as noted in the participant's ISP.

•Slip resistant flooring.

•Kitchen counter, major appliance, sink and other cabinet modifications.

•Bathroom modifications for bathing, showering, toileting and personal care needs.

•Bedroom modifications of bed, wardrobe, desks, shelving, and dressers.

•Stair gliders and stair lifts. A stair lift is a chair or platform that travels on a rail, installed to follow the slope and direction of a staircase, which allows a user to ride up and down stairs safely.

•Workroom modifications to desks and other working areas.

All adaptations to the household shall be provided in accordance with applicable building codes.

This service must be delivered in Pennsylvania. Refer to the Provider Specification section below for criteria on provider requirements.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Maximum state and federal funding participation is limited to $20,000 per participant during a 10-year period. The 10-year period begins with the first utilization of authorized Home Accessibility Adaptations. A new $20,000 limit can be applied when the participant moves to a new home. In situations of joint custody (as determined by an official court order) or other situations where a participant divides their time between official residences, the adaptations must be allowable services and must be completed within the overall monetary limit of $20,000 for this service.

Building a new room is excluded. Durable medical equipment is excluded.

Home accessibility adaptations are limited to participants residing in private homes (including homes owned or leased by parents/relatives with whom the participant resides and family living homes that are privately owned, rented, or leased by the host family).

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify)*:

Providers with a waiver service location in Pennsylvania must have a Pennsylvania contractor's license.

Providers with a waiver service location in states contiguous to Pennsylvania must have a comparable license.

Certificate *(specify)*:

Other Standard *(specify)*:

1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Adhere to all applicable local and state codes.

3.Have Commercial General Liability Insurance.

4.Have Workers' Compensation Insurance in accordance with state statute.

5.Comply with the Pennsylvania Home Improvement Consumer Protection Act.

6.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify)*:

Providers with a waiver service location in Pennsylvania must have a Pennsylvania contractor's license.

Providers with a waiver service location in states contiguous to Pennsylvania must have a comparable license.

Certificate *(specify)*:

Other Standard *(specify)*:

1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Adhere to all applicable local and state codes.

3.Comply with the Pennsylvania Home Improvement Consumer Protection Act.

4.Have Workers' Compensation Insurance in accordance state statute.

5.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Supplies

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Specialized Supplies consist of incontinence supplies that are medically necessary and are not a covered service through the MA State Plan, Medicare or private insurance. Services must be provided under the MA State Plan, Medicare and/or private insurance plans until the plan limitations have been reached. Supplies are limited to diapers, incontinence pads, cleansing wipes, underpads, and vinyl or latex gloves.

During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is limited to $500 per participant per fiscal year.

This service is not available to participants who reside in licensed or unlicensed residential habilitation settings.

Specialized Supplies consist of incontinence supplies that are medically necessary and are not a covered service through the MA State Plan which includes EPSDT, Medicare or private insurance. Specialized Supplies will be provided under the MA State Plan including EPSDT, Medicare and/or private insurance plans until the plan limitations have been reached.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supplier

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Supplies

Provider Category:
Agency
Provider Type:
Supplier
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania. (A company that the provider secures the item(s) from can be located anywhere.)Adhere to all applicable local and state codes.

2.Comply with Department standards related to provider qualifications.
Verification of Provider Qualifications
Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transitional Work Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Transitional Work Services consist of supporting participants in transitioning to integrated, competitive employment through work that occurs in a location other than a facility subject to 55 Pa. Code Chapter 2380 or Chapter 2390 regulations. Transitional work service options include mobile work force, work station in industry, affirmative industry, and enclave.

A Mobile Work Force uses teams of individuals, supervised by a training/job supervisor, who conduct service activities away from an agency or facility. The provider agency contracts with an outside organization or business to perform maintenance, lawn care, janitorial services, or similar tasks and the individuals are paid by the provider. A Work Station in Industry involves individual or group training of participants at an industry site. Training is conducted by a provider training/job supervisor or by a representative of the industry, and is phased out as the participant(s) demonstrates job expertise and meets established production rates. Affirmative Industry is operated as an integrated business, where disabled and non-disabled employees work together to carry out the job functions of the business. Enclave is a business model where disabled participants are employed by a business/industry to perform specific job functions while working alongside non-disabled workers. The goal for this service is competitive employment. Participants receiving this service must have an employment outcome included in their ISP.

The service also includes transportation that is an integral component of the service, for example, transportation to a work site. The Transitional Work provider is not, however, responsible for transportation to and from a participant's home, unless the provider is designated as the transportation provider in the participant's ISP. In this case, the transportation service must be billed as a discrete service.

This service may be provided at the following levels:
•Basic Staff Support - The provision of the service at a staff-to-individual ratio of 1:10 to >1:6.

•Level 1 - The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.

•Level 2 - The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.

•Level 3 - The provision of the service at a staff-to-individual ratio of 1:1.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Transitional Work Services may not be rendered under the Waiver until it has been verified that the services are not available to the participant under a program funded by either the Rehabilitation Act of 1973 as amended, or IDEA. Documentation must be maintained in the file of each participant receiving Transitional Work Services to satisfy the state assurance that the service is not otherwise available to the participant under a program funded under the Rehabilitation Act of 1973 as amended or IDEA.

When Transitional Work Services are provided alone or in conjunction with Prevocational, Licensed Day Habilitation or Supported Employment services, the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 40 hours (160 15-minute units) per participant per calendar week based on a 52-week year

Transitional Work Services may not be provided at the same time as any of the following: Companion Services, the direct portion of Supported Employment, Licensed Day Habilitation, Prevocational Services and Home and Community Habilitation Services.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**

☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Work Services

Provider Category:
Agency

Provider Type:
Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the Transitional Work Service.

Other Standard *(specify)*:
Agencies must meet the following standards:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have automobile insurance for all automobiles owned, leased, and/or hired and used as a component of the Transitional Work Service.

4.Have Workers' Compensation Insurance, in accordance with state statute.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

6.Comply with Department standards related to provider qualifications.

Staff working for or contracted with agencies must meet the following standards:
1.Be at least 18 years of age.

2.Complete necessary pre/in-service training based on the ISP.

3.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

4.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

5.Have a valid driver's license if the operation of a vehicle is necessary to provide Transitional Work Services.

6.Agree to carry out the Transitional Work outcomes included in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Transportation is a direct service that enables participants to access services and activities specified in their approved ISP. This service does not include transportation that is an integral part of the provision of another discrete Waiver service, nor does it include transportation associated with Residential Habilitation Services, as transportation in these situations is built into the rate for the other Waiver services.

Transportation services consist of:

1.Transportation (Mile). This transportation service is delivered by providers, family members, and other licensed drivers. Transportation Mile is used to reimburse the owner of the vehicle or other qualified licensed driver who transports the participant to and from services and resources specified in the participant's ISP. The unit of service is one mile. Mileage will be paid round trip. A round trip is defined as from the point of first pick-up to the service destination and the return distance to the point of origin.

When transportation is provided to more than one participant at a time, the provider will divide the shared miles equitably among the participants to whom transportation is provided. The provider is required (or it is the legal employer's responsibility under the VF/EA model) to track mileage, allocate a portion to each participant and provide that information to the Supports Coordinator for inclusion in the participant's ISP. This will be monitored through routine provider monitoring activities.

2.Public Transportation. Public transportation services are provided to or purchased for participants to enable them to gain access to services and resources specified in their ISPs. The utilization of public transportation promotes self-determination and is made available to participants as a cost-effective means of accessing services and activities. Public transportation may be purchased by an OHCDS for participants who do not self-direct or Financial Management Service Organizations for participants who are self-directing when the public

transportation vendor does not elect to enroll directly with ODP. Public transportation purchased for a participant may be provided to the participant on an outcome basis.

3.Transportation – Trip. This service is transportation provided to participants for which costs are determined on a per trip basis. A trip is either transportation to a service from a participant's private home or from the service to the participant's home. Taking a participant to a service and returning the participant to his/her home is considered two trips or two units of service. Trip distances are defined by ODP through the use of zones. Zones are defined as follows: Zone 1 – greater than 0 and up to 20 miles; Zone 2 – greater than 20 and up to 40 miles; and Zone 3 – greater than 40 and up to 60 miles. Providers that transport more than 6 participants are required to have an aide on the vehicle. If a provider transports 6 or fewer participants, the provider has the discretion to determine if an aide is required. The determination must be based upon the needs of the participants, the provider's ability to ensure the health and welfare of participants and be consistent with ODP requirements for safe transportation.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Relative/Legal Guardian
Agency	Agency
Individual	Individual, Non-Relative/Non-Legal Guardian

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual

Provider Type:
Relative/Legal Guardian

Provider Qualifications

License *(specify)*:
Must have a valid driver's license.

Certificate *(specify)*:
Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used to provide the Transportation Service.

Must have PUC Certification, when required by state statute or comparable certificate in contiguous states.

Other Standard *(specify):*
1.Be a legal resident of Pennsylvania or a state contiguous to Pennsylvania with supporting documentation (for SSWs or vendors in the VF/EA FMS option).

2.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania (for individual providers that are not SSWs or vendors in the VF/EA FMS option).

3.Be at least 18 years of age.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Have automobile insurance for all automobiles owned, leased, and/or hired and used to provide the Transportation Service.

7.Have Workers' Compensation Insurance, in accordance with state statute.

8.Agree to carry out the Transportation outcomes included in the ISP.

9.Be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

10.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications

License *(specify):*
Employees (direct, contracted, or in a consulting capacity) providing Transportation must have a valid driver's license.
Certificate *(specify):*
Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used to provide the Transportation Service.

Must have PUC Certification, when required by state statute or comparable certificate in contiguous states.
Other Standard *(specify):*
Agencies must meet the following standards:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Have Commercial General Liability Insurance.

3.Have automobile insurance for all automobiles owned, leased, and/or hired and used to provide the Transportation Service.

4.Have Workers' Compensation Insurance, in accordance with state statute.

5.Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

6.Comply with Department standards related to provider qualifications.

Drivers and aides working for or contracted with agencies must meet the following standards:
1.Be at least 18 years of age.

2.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

3.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

4.Agree to carry out the Transportation outcomes included in the ISP.

5.Have a valid driver's license if the operation of a vehicle is necessary to provide Transportation Services.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual

Provider Type:
Individual, Non-Relative/Non-Legal Guardian

Provider Qualifications

License *(specify):*
Must have a valid driver's license.
Certificate *(specify):*
Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used to provide the Transportation Service.

Must have a Public Utility Commission (PUC) Certification, when required by state statute or comparable certificate in contiguous states.
Other Standard *(specify):*
1.Be a legal resident of Pennsylvania or a state contiguous to Pennsylvania with supporting documentation (for SSWs or vendors in the VF/EA FMS option).

2.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania (for individual providers that are not SSWs or vendors in the VF/EA FMS option).

3.Be at least 18 years of age.

4.Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

5.Have child abuse clearance (when the Waiver participant is under age 18) as per 23 Pa. C.S. Chapter 63.

6.Have automobile insurance for all automobiles owned, leased, and/or hired and used to provide the

Transportation Service.

7.Have Workers' Compensation Insurance, in accordance with state statute.

8.Agree to carry out the Transportation outcomes included in the ISP.

9.Be trained to meet the unique needs of the participant which includes but is not limited to communication, mobility and behavioral needs.

10.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODP or its Designee

Frequency of Verification:

At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Accessibility Adaptations

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Vehicle accessibility adaptations consist of certain modifications to the vehicle that the participant uses as his or her primary means of transportation to meet his or her needs. The modifications must be necessary due to the participant's disability. The vehicle that is adapted may be owned by the participant, a family member with whom the participant lives, or a non-relative who provides primary support to the participant and is not a paid provider agency of services. This service may also be used to adapt a privately owned vehicle of a life sharing host when the vehicle is not owned by the Family Living provider agency.

Vehicle modifications consist of installation, repair, maintenance, and extended warranties for the modifications. Regularly scheduled upkeep and maintenance of the vehicle, including warranties that cover the entire vehicle,

except for upkeep and maintenance of the modifications, is excluded.

The waiver cannot be used to purchase vehicles for waiver recipients, their families or legal guardians; however, this service can be used to fund the portion of a new or used vehicle purchase that relates to the cost of accessibility adaptations. In order to fund these types of adaptations, a clear breakdown of purchase price versus adaptation is required.

These adaptations funded through the Waiver are limited to the following:
•Vehicular lifts.

•Interior alterations to seats, head and leg rests, and belts.

•Customized devices necessary for the participant to be transported safely in the community, including driver control devices.

•Raising the roof or lowering the floor to accommodate wheelchairs.

Refer to the Provider Specification section below for criteria on provider requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Maximum state and federal funding participation is limited to $10,000 per participant during a 5-year period. The 5-year period begins with the first utilization of authorized Vehicle Accessibility Adaptations.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
1.Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.

2.Adhere to all applicable local and state codes.

3.Have Commercial General Liability Insurance.

4.Have Workers' Compensation Insurance in accordance with state statute.

5.Comply with Department standards related to provider qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:
ODP or its Designee
Frequency of Verification:
At least every 2 years and more frequently when deemed necessary by ODP

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

ODP requires criminal background checks for all employees/workers that come in contact with any waiver participant; and child abuse clearances on all employees that come in contact with waiver participants who are under the age of 18. Specific requirements for criminal background checks are included in 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15 (Older Adult Protective Services Act, OAPSA). OAPSA requires that criminal background checks are requested from the Pennsylvania State Police prior to the applicant's date of hire. If the

applicant has not been a resident of the Commonwealth for the two years immediately preceding the date of application, a report of Federal criminal history record must be requested from the Federal Bureau of Investigation (FBI) in addition to a criminal history record from the Pennsylvania State Police.

ODP requires child abuse clearances and FBI checks on all employees that come in contact with waiver participants who are under the age of 18. Specific requirements for these clearances are included in 23 Pa. C.S. Chapter 63.

An agency may provisionally hire an employee pending receipt of a criminal history check, as applicable, if the following conditions are met:
•A provisionally-hired employee shall have applied for a criminal history check, as required, and give the provider a copy of the completed criminal history request form and child abuse form.

•A provider may not hire a person provisionally if the provider has knowledge that the person would be disqualified for employment under 18 Pa. C.S. § 4911 (relating to tampering with public record information).

•A provisionally-hired employee shall swear or affirm in writing that he has not been disqualified from employment or referral under this chapter.

•A provider shall not permit the provisionally-hired employee awaiting a criminal history background check or child abuse check to work alone with a participant.

•A provider shall monitor a provisionally-hired employee awaiting a criminal history check or child abuse check through random, direct observation and participant feedback. The results of monitoring shall be documented in the prospective employee's file.

•The period of provisional hire of an employee who is and has been, for a period of two years or more, a resident of this Commonwealth, may not exceed 30 days. The period of provisional hire of an employee who has not been a resident of this Commonwealth for two years or more may not exceed 90 days.

Compliance with background check requirements is verified through initial and ongoing provider qualification reviews, as well as provider monitoring conducted by ODP or the ODP Designee. For licensed providers, compliance with the Pennsylvania Code is also verified through annual licensing inspections.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- (●) **No. The State does not conduct abuse registry screening.**
- ( ) **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ( ) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- (●) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon**

request through the Medicaid agency or the operating agency (if applicable).

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
55 Pa. Code Chapter 3800 (Child Residential Facilities)	
55 Pa. Code Chapter 6500 (Family Living Homes)	
55 Pa. Code Chapter 6400 (Community Homes)	
55 Pa. Code Chapter 5310 (Community Rehabilitative Residential Services)	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Larger facilities are licensed through regulation chapters that are based on the principle of normalization, which defines the right of the individual with intellectual disabilities to live a life which is as close as possible in all aspects to the life which any member of the community might choose. The design of the service shall be made with the participant's unique needs in mind so that the service will facilitate the participant's ongoing growth and development. The service is individualized to meet the needs of participants, as per their person-centered ISP. Regulatory requirements are verified through annual licensing inspections, while the implementation of services as specified in the participant's ISP are monitored by Supports Coordinators, ODP or the ODP Designee through various oversight mechanisms.

ODP approves the setting size for certain licensed residential settings (i.e. settings licensed under 55 Pa. Code Chapter 6400, Community Homes). This is referred to as approved program capacity which is established by the Department for certain licensed residential settings based on the maximum number of individuals who, on any given day throughout the fiscal year, are authorized (includes all payment types) to receive Residential Habilitation Services at that site.

Approved program capacity for specific service locations is determined by the Regional Waiver Capacity managers for homes licensed under 55 Pa. Code Chapter 6400. The baseline determination was developed using the number of individuals being supported in the home for the FY 2009-2010 cost report and authorizations per home, including base and private funding and provider surveys. Requests to revise the approved program capacity will be approved or denied by the Regional Program Manager on a case-by-case basis.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

55 Pa. Code Chapter 3800 (Child Residential Facilities)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Behavioral Support	☐
Assistive Technology	☐
Transitional Work Services	☐
Respite	☑
Nursing	☐
Education Support Services	☐

Therapy Services	☐
Residential Habilitation	☑
Supports Broker Services	☐
Supported Employment - Job Finding and Job Support	☐
Vehicle Accessibility Adaptations	☐
Home Accessibility Adaptations	☐
Licensed Day Habilitation	☐
Specialized Supplies	☐
Prevocational Services	☐
Home and Community Habilitation (Unlicensed)	☐
Supports Coordination	☐
Homemaker/Chore	☐
Transportation	☐
Companion	☐

Facility Capacity Limit:

8

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

55 Pa. Code Chapter 6500 (Family Living Homes)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Behavioral Support	☐
Assistive Technology	☐
Transitional Work Services	☐
Respite	☑
Nursing	☐
Education Support Services	☐
Therapy Services	☐
Residential Habilitation	☑
Supports Broker Services	☐
Supported Employment - Job Finding and Job Support	☐
Vehicle Accessibility Adaptations	☐
Home Accessibility Adaptations	☐
Licensed Day Habilitation	☐
Specialized Supplies	☐
Prevocational Services	☐
Home and Community Habilitation (Unlicensed)	☐
Supports Coordination	☐
Homemaker/Chore	☐
Transportation	☐
Companion	☐

Facility Capacity Limit:

2

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed

Admission policies	✓
Physical environment	✓
Sanitation	✓
Safety	✓
Staff : resident ratios	✓
Staff training and qualifications	✓
Staff supervision	✓
Resident rights	✓
Medication administration	✓
Use of restrictive interventions	✓
Incident reporting	✓
Provision of or arrangement for necessary health services	✓

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

55 Pa. Code Chapter 6400 (Community Homes)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Behavioral Support	
Assistive Technology	
Transitional Work Services	
Respite	✓
Nursing	
Education Support Services	
Therapy Services	
Residential Habilitation	✓
Supports Broker Services	
Supported Employment - Job Finding and Job Support	
Vehicle Accessibility Adaptations	
Home Accessibility Adaptations	

Licensed Day Habilitation	☐
Specialized Supplies	☐
Prevocational Services	☐
Home and Community Habilitation (Unlicensed)	☐
Supports Coordination	☐
Homemaker/Chore	☐
Transportation	☐
Companion	☐

Facility Capacity Limit:

8 or up to the approved program capacity, whichever is less

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

55 Pa. Code Chapter 5310 (Community Rehabilitative Residential Services)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Behavioral Support	☐
Assistive Technology	☐
Transitional Work Services	☐
Respite	☑
Nursing	☐
Education Support Services	☐
Therapy Services	☐
Residential Habilitation	☑
Supports Broker Services	☐
Supported Employment - Job Finding and Job Support	☐
Vehicle Accessibility Adaptations	☐
Home Accessibility Adaptations	☐
Licensed Day Habilitation	☐
Specialized Supplies	☐
Prevocational Services	☐
Home and Community Habilitation (Unlicensed)	☐
Supports Coordination	☐
Homemaker/Chore	☐
Transportation	☐
Companion	☐

Facility Capacity Limit:

8

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑

Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

○ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**

◉ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

Legally responsible individuals may be paid to provide services funded through the Waiver on a service-by-service basis. A legally responsible individual is a person who has legal obligation under the provisions of law to care for another person, including parents of minors (natural or adoptive), spouses, and legally-assigned relative caregivers of minor children. These individuals may be paid to provide Waiver services when the following conditions are met:
• The service is considered extraordinary care, which means it is not part of the supports the legally responsible individual is ordinarily obligated to provide;

•The service would otherwise need to be provided by a qualified provider of services funded under the Waiver; and

•The service is provided by a legally responsible individual who meets the qualification criteria that are established by ODP in Appendix C-3 of the approved Waivers.

Services that legally responsible individuals can provide are limited to the following: Home and Community Habilitation (Unlicensed), Supported Employment and Transportation (Mile).

Payments to legally responsible individuals who provide services are made through a Financial Management

Services (FMS) Organization or a provider agency. Payments are based upon time sheets submitted by the legally responsible individual to the FMS or agency, which is consistent with the participant's authorized services on their ISP. The ODP designee is responsible to ensure that payments are only made for services that are authorized on the participant's approved ISP. The legally responsible individual who provides services must document service delivery per Department standards, 55 Pa. Code Chapter 1101 (Medical Assistance Regulations) and ODP policy requirements.

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Relatives/legal guardians may be paid to provide services funded through the Waiver on a service-by-service basis. A relative is any of the following who have not been assigned as legal guardian for the participant: a parent (natural or adoptive) of an adult, a stepparent of an adult child, grandparent, brother, sister, half-brother, half-sister, aunt, uncle, niece, nephew, adult child or stepchild of a parent with an intellectual disability or adult grandchild of a grandparent with an intellectual disability. For the purposes of this policy, a legal guardian is a person who has legal standing to make decisions on behalf of a minor or adult (e.g. a guardian who has been appointed by the court). The definition of a legal guardian does not apply to agency providers, but does apply to the person actually rendering service to a participant. These individuals may be paid to provide Waiver services when the following conditions are met:
•The service provided is not a function that the relative or legal guardian would normally provide for the participant without charge in the usual relationship among members of a nuclear family;

•The service would otherwise need to be provided by a qualified provider of services funded under the Waiver; and

•The service is provided by a relative or legal guardian who meets the qualification criteria that are established by ODP in Appendix C-3 of the approved Waiver.

Services that relatives/legal guardians can provide are limited to the following: Home and Community Habilitation (Unlicensed), Supported Employment and Transportation (Mile). Relatives/legal guardians who are not the participant's primary caregiver, common law employer or managing employer may also provide Supports Broker Services and Waiver funded Respite Services when the conditions listed above are met.

Payments to relatives and legal guardians who provide services are made through a Financial Management Services (FMS) Provider / Organization, or a provider agency. Payments are based upon time sheets submitted by the relative/legal guardian to the FMS or agency, which is consistent with the participant's authorized services on his or her ISP. The ODP designee is responsible to ensure that payments are only made for services that are authorized on the participant's approved ISP. The relative or legal guardian who provides services must document service delivery per Department standards and ODP policy requirements.

- **Other policy.**

Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Providers interested in providing Waiver services contact the AE or ODP to obtain information on provider qualification and enrollment, or are referred by waiver participants. Providers may also access information on the DPW website (www.dpw.state.pa.us) and the ODP Consulting System (OCS) website (www.odpconsulting.net). ODP delegates the responsibility to determine whether interested providers meet Waiver provider qualification criteria, as outlined in the approved Consolidated Waiver, to ODP designees. This excludes Supports Coordination providers, which are qualified by ODP. After the ODP designee or ODP qualifies the provider, as per the qualification criteria outlined in Appendix C-3 and as per the ODP established provider qualification process, the provider enrolling directly with ODP is able to enter service information into the ODP Services and Supports Directory and will sign an ODP Waiver Provider Agreement.

Waiver participants have free choice of willing and qualified Waiver providers to provide needed services in the participant's approved ISP.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.a.1 Number and percent of new providers that meet required license and/or certification standards and adhere to other state standards prior to furnishing waiver services. Percent = number of new providers that meet required license and/or certification standards and adhere to other state standards prior to furnishing waiver services/all new providers that require license and/or certification.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enrollment Unit Spreadsheet

Responsible Party for	Frequency of data	Sampling Approach

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Administrative Entities	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

a.i.a.2 Number and percent of current providers that continue to meet required licensure and/or certification standards and adhere to other state standards. Percent = number of current providers that continue to meet required licensure and/or certification standards and adhere to other state standards /all providers that require licensure and/or certification.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Administrative Entities	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.b.1 Number and percent of new non-licensed, non-certified providers that meet initial waiver requirements. Percent = number of new non-licensed, non-certified providers that meet initial waiver requirements/all new non-licensed, non-certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enrollment Unit Spreadsheet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Administrative Entities	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.b.2 Number and percent of current non-licensed, non-certified providers that continue to meet waiver requirements. Percent = number of current non-licensed, non-certified providers that continue to meet waiver requirements /all current non-licensed, non-certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: Administrative Entities	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.b.3 Number and percent of providers delivering services to participants who are self-directing that meet initial requirements. Percent = number of providers delivering services to participants who are self-directing that meet initial requirements/all providers delivering services to participants who are self-directing.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODP Monitoring of Vendor Fiscal Service Provider

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.b.4 Number and percent of providers delivering services to participants who are self-directing that continue to meet requirements. Percent = number of providers delivering services to participants who are self-directing that continue to

meet requirements/all current providers delivering services to participants who are self-directing.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODP Monitoring of Vendor Fiscal Service Provider

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.c.1 Number and percent of licensed providers that meet training requirements in accordance with state requirements in the approved waiver. Percent = number of licensed providers that meet training requirements in accordance with state requirements in the approved waiver/all licensed providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Licensing Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.c.2 Number and percent of non-licensed providers that meet training requirements in accordance with state requirements in the approved waiver. Percent = number of non-licensed providers that meet training requirements in accordance with state requirements in the approved waiver/all non-licensed providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: Administrative Entities	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Department conducts licensing activities for licensed residential, licensed day habilitation and prevocational services.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Performance Measure a.i.a.1. Number and percent of new providers that meet required license and/or certification standards and adhere to other state standards prior to furnishing waiver services.
New provider qualification applications are reviewed by AEs. Provider applications that do not meet requirements are denied by the AE and those providers are not enrolled in the PROMISe™ claims processing system, cannot be authorized to deliver services in an ISP, and cannot receive payment for services. Providers

denied qualification will receive written notice of the decision, indicating which requirements have not been met along with information regarding their right to initiate the appeal process as specified in 55 Pa. Code Chapter 41. Providers may resubmit an application for consideration along with additional documentation that such requirements have been met.

Performance Measure a.i.a.2. Number and percent of current providers that meet required licensure and/or certification standards and adhere to other state standards ongoing. Current providers are expected to provide documentation to AEs indicating that they have maintained required licensure and/or certification standards, and adhered to other applicable state standards at the required frequency. Each provider's specialty qualification expiration date is recorded and tracked electronically. Prior to a provider's qualification expiration date, the AE and the provider receive alerts notifying them of the provider's impending expiration. AEs are expected to notify the provider and ascertain whether there are impediments to providing qualification documentation by the qualification expiration date and provide assistance as needed. ODP sends an advance notice to the provider at least 30 days prior to their qualification expiration date informing them that failure to submit required qualification documentation by the expiration date will result in the provider's becoming not qualified to provide the expired specialty and any expired specialty provided after the expiration date will be ineligible for reimbursement through the waiver. This notice will also inform providers that participants receiving the expiring specialty will start being transitioned to the participant's choice of willing and qualified providers and inform providers of their right to appeal as specified in 55 Pa. Code Chapter 41. ODP and the responsible AE(s) will then begin activities to transition participants from providers who have expiring specialties to the participant's choice of willing and qualified providers. On the expiration date, should the provider fail to submit qualification documentation, the provider will become not qualified to provide the expired specialty. ODP will send a letter to the provider informing them that they are not qualified to provide the specialty under the waiver, that any expired specialties provided after the expiration date are ineligible for reimbursement through the waiver and that they have the right to request a fair hearing through the Department. Should the provider desire to provide the specialty through the waiver in the future, they may reenroll for the specialty as long as they meet qualifications.

Performance Measure a.i.b.1. Number and percent of new non-licensed, non-certified providers that meet initial waiver requirements.
New provider qualification applications are reviewed by ODP or AEs. Provider applications that do not meet requirements are denied by ODP or the AE and those providers are not enrolled in the PROMISe™ claims processing system, cannot be authorized to deliver services in an ISP, and cannot receive payment for services. Providers denied qualification will receive written notice of the decision, indicating which requirements have not been met along with information regarding their right to initiate the appeal process as specified in 55 Pa. Code Chapter 41. Providers may resubmit an application for consideration along with additional documentation that such requirements have been met.

Remediation for Performance Measures a.i.b.2 through a.i.c.2 are continued in the Main Module Section B entitled Additional Information Needed (Optional).

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- (●) **No**
- ( ) **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Support Plan (ISP)

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

☐ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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

- (selected) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(A) The Supports And Information That Are Made Available To The Participant (And/Or Family Or Legal Representative, As Appropriate) To Direct And Be Actively Engaged In The Service Plan Development Process

Developing a participant's Individual Support Plan (ISP) is based on the philosophies and concepts of Positive Approaches, Everyday Lives and Person Centered-Planning that captures the true meaning of working together to empower the participant to dream, plan and create a shared commitment for his or her future. The purpose of Positive Approaches is to enable participants to lead their lives as they desire by providing supports for them to grow and develop, make their own decisions, achieve their personal goals, develop relationships, face challenges, and enjoy life as fullparticipating members of their communities. The core values of Everyday Lives are choice, control, quality, community inclusion, stability, accountability, safety, individuality, relationships, freedom, and success, contributing to the community, collaboration, and mentoring. Person Centered Planning discovers and organizes information that focuses on a participant's strengths, choices, and preferences. It involves bringing together people the participant would like to have involved in the planning process, listening to the participant, describing the participant as fully as possible with a true focus on understanding who he or she is, and dreaming and imagining with the participant of possible ways things could be different, both today and tomorrow. Integrating the values of Positive Approaches, Everyday Lives, and Person Centered Planning into the ISP maximizes participants' opportunities to incorporate their personal values, standards, and dreams into their everyday lives and their programs, services, and supports. Each team uncovers meaningful personal outcomes and works towards realizing these outcomes.

In preparation for the ISP, the Supports Coordinator encourages meaningful participation of the participant and his/her family or surrogate (future use of the term participant in this section will include surrogate when applicable) by informing them of the process and the concepts of Positive Approaches, Everyday Lives and Person Centered planning through documents issued by ODP. In assisting the participant to understand the process and who participates in it, and to understand the options for services and service delivery options, the Supports Coordinator supports the participant and his/her family in gaining the tools needed to be effective in leading and meaningfully participating in the development of their ISP. The annotated ISP, which provides a tutorial for the participant and his/her family, is used during the ISP process. In addition, there are resources available through Supports Coordinators, AEs, the DPW website and HCSIS for participants and families describing the service planning and delivery process, available services and providers, and rights and safeguards. The participant and his or her family or surrogate, determines who should be present and involved in the development of the ISP and determines the date and location of the ISP team meeting. It is important to include people who know the participant best and who will offer detailed information about the participant and his or her preferences, strengths and needs. The participant and his or

her family drive the process if they choose to do so.

If the participant uses an alternate means of communication or if his or her primary language is not English, the information gathering and ISP development process utilizes his or her primary means of communication, an interpreter, or someone who has a close enough relationship with the participant to accurately speak for him or her.

(B) The Participant's Authority To Determine Who Is Included In The Process.

In addition to providing the necessary supports and accommodations to ensure that the participant and his/her family can participate in/lead the process (including participating in meetings), the Supports Coordinator supports the participant and family or surrogate in determining who should be present and involved in the development of the ISP. Once the ISP meeting details are confirmed, the Supports Coordinator develops the ISP meeting invitation and sends to the participant's team members. Team members shall be given at least 30 calendar days advance notice to attend the ISP meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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

(A) Who Develops The Plan, Who Participates In The Process, And The Timing Of The Plan

The ISP is developed by the participant and his or her team and is facilitated by the Supports Coordinator in accordance with the ISP Bulletin, who then creates the ISP document in HCSIS. The Supports Coordinator develops the ISP based on information provided by the participant, family and the team, including recommended services and supports to address the participant's current assessed needs. The team consists of the participant, the participant's family/surrogate the Supports Coordinator, providers of service, and other people who are important in the participant's life and who the participant chooses to include.

All team members play a vital role in the development of the plan during the ISP meeting by fully participating to share knowledge, perspective and insight.

The ISP is initially developed when a participant is entering service and is updated annually thereafter during the Annual Review ISP meeting and in response to changing needs of the participant. The Supports Coordinator is responsible for developing ISPs by performing the following activities in accordance with specific requirements and timeframes as established by ODP:

•Collaborating with the participant, family, provider and other team members to coordinate a date, time, and location for the Annual Review ISP meeting at least 90 calendar days prior to the end date of the ISP.

•Coordinating information gathering and assessment activity, which includes the results from the statewide needs assessment for the Annual Review ISP meetings, at least 90 calendar days prior to the end date of the ISP.

•Distributing invitations to team members at least 30 calendar days before the ISP meeting is held.

•Facilitating the ISP meeting with all team members invited at least 60 calendar days prior to the end date of the ISP.

•Utilizing and incorporating statewide needs assessment information.

•Reviewing and updating the PUNS if needed.

•Discussing Participant Directed Services (PDS) if the participant is eligible to self-direct using one of the Financial Management Services options available for participant direction.

•Creating the ISP draft in HCSIS and recording information gathered at the ISP meeting.

•Submitting the Annual ISP to the AE for approval and authorization at least 30 calendar days prior to the end date of the ISP.

•Distributing the ISP Signature Page to the provider(s).

•Resubmit the ISP for approval and authorization within 7 calendar days of the date it was returned to the SCO for revision.

•Distributing approved and authorized ISPs to the participant, family and team members who do not have HCSIS access within 14 calendar days prior to the end date of the ISP.

The Supports Coordinator is also responsible for creating a Critical Revision to the ISP whenever there is a change in the participant's needs that requires a change in the current amount of service or type of service, a change in provider or in the amount of funding throughout the plan year.

Qualified providers of services are responsible for the following ISP roles and functions:

•Collaborating with the other team members to coordinate the date, time and location of ISP meeting.

•Completing and submitting the participant's provider assessment to the Supports Coordinator.

•Attending and participating in the Annual Review ISP meeting.

•Printing and reviewing the approved and authorized ISP.

•Implementing the ISP as written.

Licensed service providers are also required by regulation to implement the plan. Plan Regulations are found in 55 Pa. Code Chapters 6400, 6500, 2380, and 2390.

The AE is responsible at least annually to review, approve, and authorize the ISP in HCSIS within 30 calendar days prior to the end date of the ISP. Once the plan is approved and authorized, the AE notifies the Supports Coordinator and provider.

(B) The Types Of Assessments That Are Conducted To Support The Service Plan Development Process, Including Securing Information About Participant Needs, Preferences And Goals, And Health Status

ODP utilizes a multifaceted assessment process to drive the initial and ongoing ISP development. In order to gain and capture person centered information to determine the person's needs and risk factors, there is also a statewide standardized needs assessment using the Supports Intensity Scale (SIS™) for applicable populations and other assessment tools for population groups for whom the SIS™ is not designed and utilized. This approach provides not only for the identification of need, but the preferences and choices of the participant in the manner in which those needs should be addressed. The SIS™ is administered by an independent contractor, and the results are available to team members in the form of the PA Universal Summary Report. In order to receive services and to ensure that services provided can meet the needs of the participant to ensure health and welfare, all waiver participants as well as those entering the waiver must have a statewide standardized needs assessment completed once every three years. If a major change in the participant's life occurs that has a lasting impact on his or her support needs, is anticipated to last more than six months, and makes his or her standardized assessment inaccurate and no longer current, then a new assessment should be requested.

This assessment provides information essential to the ISP process as it addresses what is important both to and for the participant. Assessment results are documented in the information gathering sections relevant to the questions of the ISP.

The ISP document itself identifies information about the participant; and summarizes all the assessment, outcomes and actions needed for implementation. Information gathering for the ISP should include physical development, communication styles, learning styles, educational background, social/emotional information, medical information,

personality traits, environmental influences, interactions, preferences, relationships that impact the participant's quality of life, and an evaluation of risk. The ISP also identifies who will provide services with what frequency and specifies who holds responsibility for different aspects of plan implementation, monitoring and coordination, including those related to health care, risk mitigation, behavioral support, financial support and communications.

(C) How The Participant Is Informed Of The Services That Are Available Under The Waiver

Participants are advised of all services available under the Waiver at intake and annually during the Annual Review ISP process (or more frequently if needs change). AEs are responsible to ensure all waiver participants are informed of home and community-based services funded through the Waiver, including options related to participant directed services (PDS).

SCOs are responsible to ensure that Supports Coordinators inform and fully discuss with participants prior to the initial ISP meeting and at least annually thereafter of the right to choose among and between services and providers to support participants' needs. The Supports Coordinator assists participants in linking with chosen providers. The ISP Signature Page documents that participants were informed of their choice of providers, services, and PDS.

The ISP team discusses whether the need can be met through natural supports, family, friends, or medical professionals etc. or if the need requires the support of a paid service.
A completed ISP provides a means of achieving outcomes important to the participant by integrating natural supports and funded supports. The ISP addresses all needs that affect the participant's health and welfare, including services that, if absent, would cause the participant to be placed in an institutional setting.

D) How The Plan Development Process Ensures That The Service Plan Addresses Participant Goals, Needs(Including Health Care Needs), And Preferences

As noted above, developing a participant's ISP is based on the philosophies and concepts of Everyday Lives, Person-Centered Planning and Positive Approaches. As such, the ISP addresses the full range of participant needs, and identified goals, including those related to healthcare, employment and other issues important to the participant. The ISP identifies both waiver and non-waiver funded services needed to assist the participant in achieving the identified goals, as well as their frequency, duration and amount.

Outcomes are also an important component of the ISP and represent what is important to the participant, what the participant needs, what the participant chooses to change or what he or she would like to maintain in his or her life based on their assessed needs. Any barriers or obstacles that may affect the participant's success in achieving the Outcome are discussed to ensure these obstacles do not impact the participant's health and welfare.

(E) How Waiver And Other Services Are Coordinated

The Supports Coordinator is responsible to ensure that there is coordination between services in the ISP, available MA State Plan services and other services for which the participant is eligible. The Supports Coordinator coordinates ODP, and MA services as well as generic and informal supports.

(F) How The Plan Development Process Provides For The Assignment Of Responsibilities To Implement AndMonitor The Plan

Upon approval of the ISP, supports and services are implemented as per the service authorization. The ISP includes the frequency, amount, type and duration of each authorized services, outcome(s) attached to each service, and authorization dates, as well as the designated provider.

The Supports Coordinator is responsible to monitor and verify that participants receive services in the type, amount, duration and frequency specified in the service plan. To ensure that this process and related Supports Coordinator functions are performed in accordance with all applicable rules and guidelines, ODP conducts a 3-phase annual SCO monitoring process. There are three phases of the SCO monitoring. Phase 1 is an ongoing activity throughout the year. In phase 1, the Performance Review phase, reports are available quarterly to providers and SCOs in HCSIS. In phase 2, the Self-Reporting phase, SCOs use standardized monitoring tools to self-assess their compliance level across a variety of measures, including service plan development activity. This information allows SCOs to plan their improvement strategies to enhance the quality of services and prepare for their on-site audit. The data gathered from this phase also provides ODP with a baseline to track and trend statewide compliance of SCOs across measures. SCOs complete the self-report annually. Phase 3, the On-site Audit phase, is the validation of the self-reporting information conducted by ODP. ODP uses the same tool in the On-site Audit that was used by the provider or SCO in the Self-Reporting phase. Based on the findings of the Final Audit report and Exit Conference, the SCO

and ODP will develop a corrective action plan addressing any identified areas of concern.

(G) How And When The Plan Is Updated, Including When The Participant's Needs Change

The ISP is updated annually or sooner if the participant's needs change. A new SIS™ is conducted for major life changes impacting the services necessary to support the participant. A participant may also request a change in their ISP at anytime if there is a change in need or if the participant would like to discuss alternative services or provider options and the Supports Coordinator will facilitate the process as required.

Required participant monitoring conducted by the Supports Coordinator and the ISP monitoring conducted by all team members prompt the Supports Coordinator and team to examine and assure that the participant receives the appropriate quality, type, duration and frequency of services and benefits as described in the ISP or whether changes necessitate an update to the ISP. When the Supports Coordinator or team members identify gaps between the ISP and assessed needs, the Supports Coordinator is required to document the change or gap and take appropriate action to resolve.

The Supports Coordinator monitors the ISP using a standardized monitoring tool and enters the results into HCSIS. AE monitoring ensures that reasonable safeguards exist for the participant's health and well-being in the home and community. ODP, through the oversight of AEs and SCO monitoring, monitors participants ISPs for compliance with Waiver requirements and ISP policies. In addition, the participant may be asked to participate in other external monitoring such as IM4Q.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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

The assessment process described above also identifies potential risks for the participant. Through the ISP development process, the team develops strategies to identify, reduce and address identified risks. Each ISP contains detailed information on supports and strategies designed to mitigate risk to the participant which includes a back-up plan specific to the participant. The provider develops a back-up plan that outlines how the provider will provide the authorized service(s). The back-up plan must then be shared with the Supports Coordinator, the participant and the team. These back-up plans are developed with the unique needs and risk factors of the participant in mind and are incorporated into the ISP by the Supports Coordinator to ensure that the entire team is aware of the strategies necessary to reduce and, when needed, address risks. The strategies identified to both mitigate and deal with risks reflect the underlying person centered principles of the process and are structured in a manner that reflects and supports participant preferences and goals.

Additionally, information relevant to the participant from Independent Monitoring For Quality, ODP oversight of AEs, Incident Management, complaint resolution, and other feedback shall be incorporated and reviewed annually during participants' ISPs when that information will impact participants' health and welfare, services and supports the participant receives, or participants' ability to have an everyday life.

The Supports Coordinator, providers, and other ISP team members collaborate to ensure that the participant seeks and receives necessary health care services. If a participant refuses routine medical or dental examination or treatment, the refusal and continued attempts to teach the participant about the need for health care shall be documented in the participant's record.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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

The Supports Coordinator shares provider information with the participant and their team in preparation for the planning process and ultimately the participant and his or her family exercise choice in the selection of willing and

qualified providers. The Supports Coordinator provides information regarding potential willing and qualified providers for necessary services upon enrollment, at the initial plan meeting and at least annually thereafter by sharing the statewide Services and Supports Directory (SSD) and through discussions with the participant and his/her family or surrogate. Information from the SSD can be reviewed through the Internet, or via hard copy printed by the Supports Coordinator or AE.

Providers that are willing and qualified to provide services necessary to support the participant's assessed needs and Outcomes are reviewed with the participant and his or her family or surrogate. The participant and his or her family shall exercise choice in the selection of willing and qualified providers. This selection is documented on the ISP Signature Page. Supports Coordinators make timely referrals to chosen providers based on the selections made by the participant and the other members of their team, and can coordinate a team meeting in the event that the participant seeks to change providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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

After the ISP planning meeting, the Supports Coordinator completes the ISP in HCSIS and it is submitted to the AE for approval in accordance with ODP policy and guidelines. Once approved, the AE authorizes services.

ODP reviews a proportionate representative random sample of ISPs for waiver participants retrospectively as part of the statewide AE Oversight Monitoring Process, which is outlined in Appendix A-6. The AE Oversight Monitoring Process involves the review of a representative sample of ISPs to ensure:

• ISPs address all assessed needs;

• ISPs document the frequency;

• ISPs address personal outcomes;

• ISP outcomes relate to the participant's preferences and needs;

• ISPs are updated at least annually, and as needed based on changes in need;

• Team members are invited to ISP meetings; and

• ISPs are authorized prior to the receipt of Waiver services.

Other triggers for the review of ISPs by ODP include identification of critical participant issues through incident management reviews, ODP Regional Risk Management committee meetings, and/or complaints. ISPs may be reviewed as part of the ODP Service Review procedures for the review of formal fair hearing requests that involve denial, reduction, suspension, or termination of waiver services for participants. ISPs are also reviewed in order to make determinations for prior authorization of services and ODPs exception policy to ensure documentation of assessed need.

ODP retains the final authority related to the content and funding attached to ISPs. ODP reviews a sample of ISPs through the AE Oversight Monitoring Process. Any issues identified through the review of ISPs will be presented to the AE for remediation. ODP will expect the AE to outline a plan to correct the issue(s), subject to approval by ODP.

In addition, through the SCO oversight and monitoring process, ODP will ensure that the Supports Coordinators are fulfilling their obligations in this process as well.

Results and findings related to the review of ISPs are an important component of ODP's quality management strategy, as they relate to the assurance of meeting waiver participants' identified needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

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

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

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

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

(A) The Entity (Entities) Responsible For Monitoring The Implementation Of The Service Plan And Participant Health And Welfare

The AE, the Supports Coordinator, and ODP are the entities responsible for monitoring the implementation of the ISP to ensure that Waiver services are furnished in accordance with the ISP and consistent with safeguarding the participants' health and welfare. If the AE is also the Supports Coordination Organization, the same ISP monitoring requirements apply.

(B) The Monitoring And Follow-Up Method(S) That Are Used

The Supports Coordinator monitors the implementation of the ISP regularly to ensure that services meet the participants' needs as identified in the ISP, that participants have access to services, exercise free choice of provider, and that the services, waiver and non-waiver, are furnished at the duration, frequency and service type as specified in the plan. Emergency back up plans, detailed in each participants' ISP which ensure the continuity of services, and participant health and welfare assurances are included in the monitoring process. Both telephone conversations and face-to-face visits are utilized as monitoring methods.

Information is systemically collected about the monitoring results and follow-up action are recorded by the Supports Coordinator on a standardized form determined by ODP which is entered into HCSIS and/or retained in the participants record. SCOs are responsible to monitor the quality of the Supports Coordinators service and implementation of the service plan. ODP also provides oversight through the SCO provider monitoring process and AE oversight monitoring process.

AEs monitor implementation of the ISP through the approval of ISPs and authorizations of services as initially developed and as revisions are made to address changing needs of the participants. This information collected and

recorded in HCSIS and is reviewed by ODP through oversight monitoring of the AEs. AEs also monitor the implementation of the ISP through the Provider Monitoring process.

ODP also incorporates monitoring, such as Independent Monitoring for Quality Surveys (IM4Q), sample reviews and AE Oversight Monitoring Process which include protocols for monitoring by AE or ODP staff for follow up and remediation of identified problems and the Intellectual Disabilities Customer Service Line protocol.

(C) The Frequency With Which Monitoring Is Performed.

For participants in the Consolidated Waiver who receive a monthly service, the Supports Coordinator shall conduct a minimum of three (3) face-to-face monitoring visits every three (3) calendar months. Of these visits:

• At least one (1) of the visits must take place at the waiver participant's residence;

• One (1) visit must take place at the waiver participant's day service; and

• One (1) visit may take place at any place agreeable to the waiver participant.

Deviations of the minimum monitoring frequency that involve monitoring at a frequency and location that differ from the above requirements are permitted for participants living with family members under the following circumstances:

•The waiver participant and/or their representative requests the deviation;

•The deviation is included in the waiver participant's approved ISP; and

•There are alternative mechanisms in place to ensure the waiver participant's health and welfare, and these mechanisms are included in the participant's approved ISP.

Deviations in monitoring frequency may not result in monitoring that takes place at a frequency less than four (4)face-to-face monitoring visits per calendar year. Deviations in monitoring location may only be approved if the deviation allows for monitoring of service delivery at authorized service locations. Deviations in monitoring frequency and location must be prior approved by ODP.

If a monthly service is not provided as per the conditions outlined in Appendix B-6-a-ii, deviations of monitoring frequency and location are not permitted. For these situations, ODP requires a face-to-face monitoring visit by Supports Coordinators at least once every calendar month during the period of time when a monthly service is not provided.

AEs monitor implementation of the ISP on a periodic basis through the approval of ISPs and authorizations of services as initially developed and as revisions are made to address changing needs of the participants. This information is collected and recorded in HCSIS and is reviewed by ODP through oversight monitoring of the AEs. AEs also monitor the implementation of the service plan bi-annually through Provider Monitoring process.

ODP monitors through annual AE oversight monitoring, annual SCO monitoring as well as periodic review and follow up to issues as identified through external monitoring and customer service calls.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. **Sub-Assurances:**

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.a.1. Number and percent of waiver participants who have all assessed needs addressed in the ISP through waiver funded services or other funding sources or natural supports. Percent = number of waiver participants who have all assessed needs addressed in the ISP through waiver funded services or other funding sources or natural supports/number of waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and**	☑ **Other**

	Ongoing	Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.a.2. Number and percent of waiver participants who have had a risk assessment and services and supports in the ISP to mitigate the risk where appropriate. Percent = number of waiver participants who have had a risk assessment and services and supports in the ISP to mitigate the risk where appropriate/number of waiver participants reviewed. .

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.a.3. Number and percent of waiver participants whose ISPs reflect their personal goals. Percent = number of waiver participants whose ISPs reflect their personal goals/number of waiver participants reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.b.1. Number and percent of ISPs that are developed consistent with state policies and procedures as described in the approved waiver. Percent = number of ISPs that are developed consistent with state policies and procedures as described in the approved waiver/number of waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate,

		representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.c.1. Number and percent of waiver participants whose Annual ISPs were reviewed and/or revised and approved within 365 days of the prior Annual ISP. Percent = number of waiver participants whose Annual ISPs were reviewed and/or revised and approved within 365 days of the prior Annual ISP/number of waiver participants reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.c.2. Number and percent of waiver participants whose needs changed and whose ISPs were reviewed/revised accordingly. Percent = number of waiver participants whose needs changed and whose ISPs were reviewed/revised accordingly/number of waiver participants whose needs changed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.d.1. Number and percent of ISPs in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the ISP. Percent = number of ISPs in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the ISP/number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.e.1. Number and percent of new enrollees who are afforded choice between waiver services and institutional care. Percent = number of new enrollees who are afforded choice between waiver services and institutional care (Service Preference Choice or Form 457 Effective Begin Date on or Before Waiver Begin Date)/all new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.e.2. Number and percent of waiver participants whose records document choice between and among services was offered to the participant/family. Percent = number of waiver participants whose records document choice between and among services was offered to the participant/family/number of waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence

		level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.e.3. Number and percent of waiver participants whose records document choice between and among providers was offered to the participant/family. Percent = number of waiver participants whose records document choice between and among providers was offered to the participant/family/number of waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.e.4. Number and percent of new waiver enrollees and waiver participants who are provided information on participant-directed services. Percent = number of new waiver enrollees and waiver participants who are provided information on participant-directed services/number of new waiver enrollees and waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
For Performance Measure a.i.e.1, a 100% review of data from HCSIS is reviewed monthly by ODP staff to assess compliance.

For Performance Measures a.i.a.1, a.i.a.2, a.i.a.3, a.i.b.1, a.i.c.1, a.i.d.1, a.i.e.2, a.i.e.3, a.i.e.4, ODP staff use the AEOM tool and methodology to review a proportionate, representative random sample of waiver participant records annually. For Performance Measure a.i.c.2, a subset of the proportionate, representative random sample of waiver records of participants whose needs changed is reviewed.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measure a.i.a.1. Number and percent of waiver participants who have all assessed needs addressed in the ISP through waiver funded services or other funding sources or natural supports.
Through the AEOMP, ODP reviews a sample of records to determine if participants have all assessed needs addressed in their ISPs through waiver funded services or other funding sources or natural supports. If a participant's plan does not contain evidence that all assessed needs have been reviewed and/or addressed by the participant and his/her team, the AE will work with the SCO to ensure that the ISP is revised to support the identified assessed needs. The AE will provide ODP with the ISP approval date that reflects the changes made to the ISP that correct the identified noncompliance. Remediation by the AE is expected within 30 days of notification.

Performance Measure a.i.a.2. Number and percent of waiver participants who have had a risk assessment and services and supports in the ISP to mitigate the risk where appropriate.
Through the AEOMP, ODP reviews a sample of records to determine if the required risk assessment components have been identified for each participant and that services and supports are included in the ISP to mitigate the identified risk where appropriate. If there is no evidence in the participant's record that a risk assessment has been completed, the AE will work with the SCO to ensure completion and documentation in the ISP of the risk assessment. If a participant's record does not contain evidence that services and supports have been incorporated in the ISP that mitigate a participant's identified risks, the AE will work with the SCO to ensure that the ISP is amended to include risk mitigation strategies. The AE will notify ODP of the date that the changes were made to the ISP correcting the identified noncompliance. Remediation by the AE is expected within 30 days of notification.

Performance Measure a.i.a.3. Number and percent of waiver participants whose ISPs reflect their personal goals.
Through the AEOMP, ODP reviews a sample of records to determine if outcomes listed in the ISP for a participant reflect his/her identified personal goals by reviewing relevant sections of the ISP. If there is no evidence in an ISP that a participant's identified personal goals have been incorporated, the AE will work with the SCO to ensure that the ISP is amended to include language that reflects outcomes that relate to identified personal goals. The AE will notify ODP of the date that the changes were made to the ISP correcting the identified noncompliance. Remediation by the AE is expected within 30 days of notification.

Remediation for Performance Measures a.i.b through a.i.e are continued in the Main Module Section B entitled Additional Needed Information (Optional)

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- ◉ **No**
- ○ **Yes**
  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

All Individual Support Plans (ISPs) are participant-centered, and the planning process encourages participants to identify needs, which can be incorporated through natural and paid supports. ISPs are developed through a team process, which focuses on a team approach with the participant as the center of the team. Other team members include family and friends, surrogate, Supports Coordinator, service providers, and any natural supports or community resources. Each participant has the choice of willing and qualified waiver providers. ISPs are developed annually and reviewed or revised as necessary throughout the year.

The SCO, Supports Coordinator, AE, and the FMS providers share the role to provide information to participants on the ODP self-directed options. The roles and responsibilities are included in the ODP policies for participant directed services. All participants must be provided information about the ODP self-directed options and the services that are identified as Participant Directed services (PDS). All participants who reside in a private home are offered the opportunity to exercise choice and control over participant directed services and the qualified support services workers they hire to render those services. This excludes participants who live in agency owned, leased/rented, or operated (i.e. licensed and unlicensed Family Living homes) homes. The list of PDS is included in Appendix E-1-g. The services that are identified as Participant Directed Services are communicated by ODP through Informational Packets. The information is also posted at: http://www.odpconsulting.net.

Participants are able to self-direct through the utilization of a FMS organization.
Participants may select one of two FMS models, the Agency with Choice (AWC) or Vendor Fiscal/Employer Agent (VF/EA) FMS models. The AWC FMS model is available through locally based AWC FMS providers. In the AWC model, the AWC FMS provider is the “Employer of Record” of qualified support service workers. Through this model, participants or their surrogate functions as the Managing Employer and work in a joint employer arrangement with the AWC FMS to fulfill responsibilities, such as but not limited to:

-Recruit and refer qualified support service workers to the FMS for hire;

-Participate in training of support service workers;

-Determine worker schedules;

-Determine worker responsibilities; and

-Manage the daily activities of workers.

In the AWC model, the FMS is responsible for functions such as but not limited to:
-Hiring qualified support service workers referred by participants/surrogates;

-Processing employment documents;

-Verifying that qualified support service workers meet the qualification standards outlined in Appendix C-3;

-Obtaining criminal background checks and child abuse checks, if applicable, on prospective employees;

-Invoicing PROMISe for services authorized and rendered;

-Preparing and disbursing payroll checks;

-Providing workers compensation for workers;

-Providing a variety of supports to participants/surrogates, to include employer skills training and development of a worker registry; and

-Conducting worker training as needed or requested.

The VF/EA FMS model is provided through a statewide entity on contract with ODP. In the VF/EA model, the participant or their surrogate is the “Employer” of qualified support service workers. Through this model, the participant or their surrogate has responsibility to fulfill functions such as but not limited to:

-Recruiting and hiring qualified support service workers;

-Orienting and training workers;

-Determining worker schedules;

-Determining worker responsibilities;

-Managing daily activities of workers; and

-Dismissing workers when appropriate.

Under the VF/EA model, the FMS is responsible for functions such as but not limited to:

-Functioning as the employer agent on behalf of the participant/surrogate;

-Withholding, filing, and paying Federal employment taxes, State income taxes, and workers compensation on behalf of the participant/surrogate;

-Paying workers and vendors for services rendered as per the participant's authorized ISP;

-Verifying that workers meet statewide qualification criteria for the service(s) they provide;

-Conducting criminal background checks and child abuse checks, if applicable, on prospective employees; and

-Providing employers with informational materials for enrollment of the employer and the workers into the VF/EA FMS model.

All participants acting as the employer or managing employer are afforded budget authority which enables them to designate the hourly wage paid to each qualified support service worker, in accordance with the wage ranges established by ODP. All participants self-directing their services have the flexibility to manage their services and initiate shifting units and associated funds between authorized participant directed services by requesting an adjustment in their participant directed services through their supports coordinator to accommodate changes in need

All participants who use FMS have the right to receive those services in accordance with the guiding principles of self-determination. This means that participant-directed services must be provided in a manner that affords participants and their surrogates, if applicable, choice and control over the services they receive and the qualified service support workers, vendors and providers who provide them. In addition to FMS, the Supports Broker service is available to participants who need additional support with their employer or managing employer functions.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Participants who live in a private home may utilize one of the identified participant directed options to manage some or all of their needed services that are available under this option. Participants who live in agency owned, leased/rented, or operated (i.e. licensed and unlicensed Family Living homes) homes may not direct their services through participant direction.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

ODP has developed and required distribution of standard participant directed information which includes the rights and responsibilities, the benefits and any risks associated with each participant directed option. This information is included in ODP's Pennsylvania Guide to Participant Direction, ODP policy bulletins on participant direction and the ODP approved statewide Vendor Fiscal/Employer Agent start up packet. Participants are provided with this information, as well as technical assistance on participant direction through the SCO, Supports Coordinator, AE and the FMS. The AE is responsible to provide waiver enrollees with information about participant direction during intake and enrollment. Supports Coordinators and SCOs are responsible to provide participants with information in advance of and during the planning process, annual ISP review, and upon request. Supports Coordinators also provide participants with support and assistance in order to make decision to exercise participant direction authority (ies), and will refer participants to other resources (i.e. FMS, supports brokers) as necessary. In addition, ODP sponsored training and standard information are available on the FMS options. Participants can also receive information and training on participant direction upon request from the SCO, AE, FMS, ODP and through ODP training contractors.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a

representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participants have the right to have a surrogate to perform the employer or managing employer responsibilities. The FMS is responsible to ensure that the selected surrogate agrees to fulfill the responsibilities of the employer or managing employer by ensuring the review and completion of the applicable ODP standard agreement form. If a surrogate is desired by the participant, the surrogate must:

-Effectuate the decision the participant would make for himself/herself;

-Accommodate the participant, to the extent necessary that they can participate as fully as possible in all decisions that affect them;

-Give due consideration to all information including the recommendations of other interested and involved parties; and

-Embody the guiding principles of self-determination.

If a surrogate has not been designated by a court, the participant may designate the following surrogate, as available and willing:

-A spouse (unless a formal legal action for divorce is pending);

-An adult child of the participant;

-A parent;

-An adult brother or sister;

-An adult grandchild; or

-Any adult who has knowledge of the participant's preferences and values.

A surrogate may not receive payment for this function. In addition, a surrogate may not receive payment for any Waiver services the surrogate provides to the participant they are surrogate for, with the exception of Transportation mileage reimbursement as defined in Appendix C1/C3.

The FMS must recognize the participant's surrogate as a decision-maker, and provide the surrogate with all of the information, training, and support it would typically provide to a participant who is self-directing. The FMS must fully inform the surrogate of the rights and responsibilities of a surrogate. Once fully informed, the FMS must have the surrogate review and sign an ODP standard agreement form, which must be given to the surrogate and maintained in the participant's file. The agreement lists the roles and responsibilities of the surrogate; state that the surrogate accepts the roles and responsibilities of this function; and state that the surrogate will abide by ODP policies and procedures.

ISP monitoring takes place with each participant at the minimum frequency outlined in D-2-a. Several questions on the standard ISP monitoring tool can prompt the identification of any issues with the surrogate not acting in the best interest of the participant. Issues noted on the monitoring tool are addressed by Supports Coordinators, the SCO provider, FMS, the AE and/or ODP.

The AWC FMS and the VF/EA FMS provider is required to address and report any issues identified with the surrogate's performance including compliance to the ODP policy on incident reporting and report any incident of suspected fraud or abuse.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Assistive Technology	☑	☑
Respite	☑	☑
Education Support Services	☑	☑
Supports Broker Services	☑	☑
Supported Employment - Job Finding and Job Support	☑	☑
Vehicle Accessibility Adaptations	☑	☑
Home Accessibility Adaptations	☑	☑
Specialized Supplies	☑	☑
Home and Community Habilitation (Unlicensed)	☑	☑
Homemaker/Chore	☑	☑
Transportation	☑	☑
Companion	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Services (FMS) are available through the AWC and VF/EA FMS models. AWC FMS functions are available through locally based AWC FMS providers. The locally based AWC FMS providers are identified by ODP to provide financial management services to participants in each AE. Should an AWC FMS provider decide to no longer provide AWC FMS administrative services, the AWC FMS shall provide ODP with at least 60 days written notice. Upon notification ODP will implement the ODP process for ODP to secure an alternative AWC FMS provider for the participants and the associated AE(s).

VF/EA FM Services are available through a statewide entity on contract with ODP. The statewide VF/EA FMS organization is selected by the Department.

During a transition period from one VF/EA FMS to another VF/EA FMS the SCO, AE and ODP work together to ensure a smooth transition to the new statewide VF/EA FMS and to ensure services are delivered in accordance with the participant's ISP.

FMS must be provided in accordance with applicable United States Internal Revenue Services (IRS) rules and regulations, US Department of Labor and state and local rules and regulations pertaining to support service workers, employer agents, and ODP policies.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

ODP has developed a standard methodology for reimbursing FMS administrative activities and the administrative payments to the VF/EA FMS and AWC FMS are entirely separate from the funds dedicated to the participant's budget for services.

For AWC providers, the AWC FMS provider receives a monthly per participant administrative fee for the FMS administrative service provided by the AWC FMS. The monthly administrative fee is established by ODP and the AWC FMS provider and must be applied consistently with each participant within the AWC FMS provider. Administrative claims are submitted by the AWC FMS to PROMISe and payments are made directly to the AWC FMS from the Pennsylvania Treasury.

For the VF/EA FMS model, ODP contracts with one statewide VF/EA FMS. The following administrative payments are available for participants enrolled with the statewide VF/EA FMS, are enrolling with the statewide VF/EA FMS for the first time after a date specified by ODP, or are transitioning to the new statewide VF/EA FMS from the existing statewide VF/EA FMS:

• The statewide VF/EA FMS receives a monthly per participant administrative fee for the FMS administrative service provided by the VF/EA FMS. The monthly administrative fee is established by ODP. The VF/EA FMS must apply the monthly per participant fee consistently with each participant enrolled with the VF/EA FMS.

• After a date specified by ODP, a one-time start-up administrative fee is available to be authorized for each participant for required activities related to the participant's enrollment with the statewide VF/EA FMS. The start-up administrative fee is authorized for each participant in the month prior to authorization of the ongoing monthly per participant administrative fee. The one-time start-up administrative fee is established by ODP.

• During a transition from one statewide VF/EA FMS to the newly selected VF/EA FMS the Department shall pay the new VF/EA FMS a one-time per participant administrative transition fee. This one–time per participant administrative transition fee will be implemented only during a transition and will be paid to the new VF/EA FMS once for the completion of all the required transition documents and activities in order for a

participant to enroll with the new statewide VF/EA FMS. The one-time transition administrative fee is established by ODP.

More than one of these fees (the one-time per participant administrative transition fee or the start up fee) will not be paid for the same participant in the same month.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

Criminal background check
Qualifications check

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other**

Specify:

The FMS receives and disburses funds for the payment of vendor services. The statewide VF/EA FMS and AWC FMS providers may subcontract for goods needed for a participant that have been designated as PDS vendor services. In these situations, the VF/EA and AWC FMS is responsible to ensure that subcontracted entities meet all applicable provider qualification standards for the service. In addition, the VF/EA and AWC FMS must complete the following activities for the service offered/rendered:
•Enroll in PROMISe as the provider;

•Ensure the requirements of Appendix C, including provider qualification standards, are met;

•Cooperate with provider monitoring conducted by ODP or one of its designees;

•Cooperate with other monitoring activities, such as Supports Coordination monitoring, and ensure the vendor cooperates with such monitoring when necessary; and

•Maintain documentation on service delivery.

The cost of the good or vendor service must be the same as charged to the general (or self-paying) public. Any administrative charge is included in VF/EA and AWC FMS monthly per participant fee.

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The participant (or the participant's surrogate) is the common law employer of workers who provide waiver services. A statewide VF/EA contractor is an IRS-Approved Fiscal/Employer Agent and functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law, in accordance with the ODP VF/EA FMS policy bulletin and VF/EA contract requirements. The VF/EA FMS provides specific employer agent functions that support the participant with the employer-related functions.

ODP monitors the VF/EA FMS to ensure that the contract deliverables are met and participants are in receipt of VF/EA FMS services in accordance with their ISP. The statewide VF/EA FMS is monitored by ODP at a frequency established by ODP.ODP monitors the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. AEs are also required to report any issues with the statewide FMS organization’s performance to ODP, pursuant to the AE Operating Agreement.

The locally based AWC FMS providers are monitored by AEs per the AE Operating Agreement, ODP determined monitoring frequency and in accordance with ODP policy. AEs are responsible to conduct ongoing performance monitoring of AWC FMS providers.

ODP monitors claims submitted by the AWC FMS and VF/EA FMS. Through the ODP established claims oversight methods, ODP has safeguards to ensure the payments to the FMS providers for both administrative fees and services are in accordance with all applicable regulations and requirements and maintain a consistent ratio of services to the FMS administrative costs for the participants served.

Supports Coordinators monitor participant service delivery at a frequency identified in Appendix D-2-a which includes the delivery of the administrative services provided by the AWC and VF/EA FMS.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Supports Coordination is a service furnished under the Waiver. In accordance with the Supports Coordinator core functions to locate, coordinate and monitor services the Supports Coordinators must provide participants with the ODP developed or approved information such as the, Pennsylvania Guide to Participant Direction, ODP policy bulletins on participant direction, the ODP established wage ranges and the ODP approved statewide Vendor Fiscal/Employer Agent (VF/EA) start up packet. The Supports Coordinator and SCO provide the participant with a basic overview of the participant directed options, the differences and responsibilities associated with each option. The Supports Coordinator and SCO provide contact information for the statewide

VF/EA on contract with ODP as well as the ODP designated Agency with Choice (AWC) in their Administrative Entity. The Supports Coordinator or SCO is required to share the above information during the planning process, annual ISP review meetings, and upon request. Supports Coordinators also provide participants with support and assistance to make the decision to exercise participant direction authority (ies), and refer participants to other resources (i.e. FMS, supports brokers) as necessary. If a decision is made to self-direct some or all the needed services, the participant and his or her team will then select either the AWC or VF/EA FMS option. Documentation of the choice is documented by the Supports Coordinator on the ISP Signature Page. In addition to providing information and assistance to support a participant with decisions on the option to self direct, the Supports Coordinator also supports the participant with designating a surrogate and transition activities when needed.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Behavioral Support	☐
Assistive Technology	☐
Transitional Work Services	☐
Respite	☐
Nursing	☐
Education Support Services	☐
Therapy Services	☐
Residential Habilitation	☐
Supports Broker Services	☑
Supported Employment - Job Finding and Job Support	☐
Vehicle Accessibility Adaptations	☐
Home Accessibility Adaptations	☐
Licensed Day Habilitation	☐
Specialized Supplies	☐
Prevocational Services	☐
Home and Community Habilitation (Unlicensed)	☐
Supports Coordination	☑
Homemaker/Chore	☐
Transportation	☐
Companion	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Participants or their surrogates who function as the “Employer” may access orientation and functional training or may obtain enrollment and informational materials from the statewide VF/EA FMS organization on contract with

ODP. The informational materials made available to participants and/or their surrogates are the VF/EA FMS bulletin, the Pennsylvania Guide to Participant Directed Services and the comprehensive Enrollment Packet referred to as the "start up packet".

Participants or their surrogates who function as the "Managing Employer" may access orientation, functional and ongoing training or may obtain enrollment and informational materials from the AWC FMS provider in their AE. The informational materials made available to participants and/or their surrogates by the AWC FMS, includes,the AWC FMS bulletin and the Pennsylvania Guide to Participant Directed Services (PA Guide to PDS).

AEs, SCOs, ODP and the AWC FMS share the responsibility of sharing the ODP PDS informational packet known as the PA Guide to PDS. Additional trainings can be requested from ODP or its contractor.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

If a participant or surrogate functioning as the "Employer" voluntarily terminates themselves from the VF/EA FMS participant directed model, the Supports Coordinator will provide the participant with options to choose the AWC FMS model or agency-based service options to meet their needs. Both participant-directed services and traditional service models provide similar services to meet the participant's needs. The Supports Coordinator is responsible to work with the participant, surrogate, and ISP team to ensure an effective transition between participant directed and traditional services so that there are no gaps in service. The Supports Coordinator is responsible to work with the participant, surrogate and ISP team to monitor and coordinate an effective transition between service management options so the participant's health and welfare is maintained and services are provided in accordance with the authorized ISP.

If a participant or surrogate functioning as the "Managing Employer" voluntarily terminates themselves from the AWC FMS participant directed model, the Supports Coordinator will provide the participant with the option to choose the VF/EA FMS model or agency-based service options to meet their needs. The Supports Coordinator is responsible to work with the participant, surrogate, and ISP team to ensure an effective transition between participant directed and traditional services so that there are no gaps in service. The SC is responsible to work with the participant, surrogate and ISP team to monitor and coordinate an effective transition between service management options so the participant's health and welfare is maintained and services are provided in accordance with the authorized ISP.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination will occur if the participant or their surrogate is suspected or convicted of Medicaid fraud or if the participant fails to meet the conditions of their signed agreement. Involuntary termination will also occur if there is sufficient evidence through supports coordination monitoring that the participant's assessed needs are not being met as a result of the performance by the employer or managing employer. All involuntary terminations must be approved by the appropriate ODP Regional Office.

If a participant or surrogate functioning as the "Employer" is involuntarily terminated from the VF/EA FMS participant directed model , the supports coordinator will provide the participant with options to choose a new surrogate who will fulfill the surrogate functions as required, the Agency with Choice FMS model or agency-based service options to meet their needs.

If a participant or surrogate functioning as the "Managing Employer" is involuntarily terminated from the AWC FMS participant directed model, the Supports Coordinator will provide the participant with options to choose a new surrogate who will fulfill the surrogate functions, and agency-based service options to meet their needs.

The Supports Coordinator is responsible to work with the participant, surrogate and ISP team to maintain health and welfare, monitor and coordinate an effective transition between participant directed and traditional services and monitor that services are provided in accordance with the authorized ISP.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		1000
Year 2		1000
Year 3		1000
Year 4		1050
Year 5		1050

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The participant or the participant's representative (surrogate) functions as the co-employer (managing employer) of their workers who provide the authorized services. The Agency With Choice (AWC) is the employer of record of the staff. The AWC performs the employer of record functions, payroll and human resources functions. The AWC provider is available to assist the managing employer with their managing employer related responsibilities. When needed and when authorized a Supports broker also may assist the managing employer with their employer-related functions.

Private entities function locally as AWC FMS providers. Under the AWC FMS model, the AWC FMS and the participant/surrogate must work together effectively as a team to: 1. Offer a high level of choice and control to participants/surrogates, and 2. Minimize any employer liability for the AWC FMS and the participant/surrogate. The focus of the AWC FMS is to afford participants/surrogates with the ability to be effective managing employers. (The AWC FMS is the "Employer of Record"; however, the participant/surrogate engages in managing functions, including recruiting and referring workers to the AWC FMS for hire, managing worker day-to-day responsibilities and schedules, and discharging workers from the home when necessary.) The AWC FMS must fully embrace and apply the philosophies of self- determination and self-directed support services by providing participants/surrogates with a high level of choice and control over the support services they receive and the workers who provide them. AWC FMS providers are responsible to develop and maintain a system and written policies and procedures that reflect ODP policy and afford participants/surrogates with the ability to recruit, interview, and select qualified support service workers for hire by the FMS; as well as the ability to be managing employers.

Through provider monitoring the AE is responsible to monitor the AWC/FMS. Supports Coordinators, through regular ISP monitoring, monitor the health, welfare, and quality of services and supports provided in accordance with the participant's approved ISP. Participants/surrogates may discuss concerns regarding limits on choice and control with Supports Coordinators, supports coordination supervisors, AWC FMS and AEs. Participants/surrogates may also contact ODP through the Regional Office or the ODP Customer Service Number (1-888-565-9435).

- [x] **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [x] **Refer staff to agency for hiring (co-employer)**
- [ ] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [ ] **Verify staff qualifications**
- [ ] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**

- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

For all participants a needs assessment is conducted and utilized in planning. The assessed needs are discussed by the planning team as part of the planning process which then results in the development of an ISP to meet the participants' assessed needs. The AE, Supports Coordinator/SCO and the FMS inform the participant of the rates and established wage ranges which are published by ODP. The participant's budget is established based on the total units and total costs for the waiver services authorized in the ISP or any revisions.

AEs must approve and authorize plans in accordance with the AE Operating Agreement. The FMS will have access to HCSIS to review and print the approved and authorized participant-directed services for which they will be making payment. This includes the total units and total dollars identified for the participant directed services. The participant's ISP must include the service procedure code, the total units and the total dollars for each authorized participant directed service.

ODP has established wage ranges/rates for the following participant directed services: Unlicensed Home and Community Habilitation, Supported Employment, Supports Broker Services, Homemaker/Chore, Companion, and Respite. The fees for Home Accessibility Adaptations, Vehicle Accessibility Adaptations, Adaptive Appliances/Equipment, Specialized Supplies, Respite Camp and Transportation (mile and public) are based on actual costs.

The participant directed service, total units and total dollars are used to calculate the participant directed portion of the ISP. Information packets on available participant directed services and wage ranges/rates are distributed and published on the ODP Consulting website (www.odpconsulting.net). The monthly per participant administrative fee is not included in the participant ISP waiver service total.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The Supports Coordinator informs the waiver participant of the approved and authorized services subsequent to the development and final authorization of the plan. Participants may request an adjustment in their participant directed services through their supports coordinator to accommodate changes in need. If an ISP adjustment is denied or the participant's services are reduced, the Administrative Entity is responsible to provide written notice and appeal rights to the participant. The participant may choose to appeal the denial or reduction through a formal fair hearing request. The monthly per participant administrative fee is not included in the participant ISP waiver service total.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Expenditure of participant directed services is monitored by the AE, ODP, FMS and common law employer or managing employer. The AE and ODP monitor expenditures through the review and payment of claims. AWC FMS providers invoice for services provided, and also process and disburse payroll checks, and are responsible to do so in accordance with the participant's authorized ISP. The AWC FMS provides monthly statements to the managing employers so they can appropriately track utilization of services and the corresponding funds. The VF/EA FMS organization on contract with the State is responsible for invoicing services provided, and also processing and disbursing payroll checks, and is responsible to do so in accordance with the participant's authorized ISP. The VF/EA FMS organization records funds received and disbursed, as well as remaining balances for each participant. They also distribute monthly utilization statements to the employer.

Standardized ISP monitoring is used to identify and address potential service delivery problems, including those associated with over- or under-utilization of authorized services.

If issues, such as over-utilization or under-utilization, related to participant directed services are recognized, the supports coordinator and/or the FMS are responsible to notify the employer of record or managing employer. The AE is responsible to review the situation and ensure that necessary plan and budget changes are made in a timely fashion, or to ensure appropriate notification of their findings are provided to the Supports Coordinator, employer of record, managing employer, FMS and ODP.

The statewide VF/EA FMS and locally based AWC FMS will also monitor the participant's and/or their surrogate's satisfaction with the participant-directed services they receive.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

An individual/participant is advised routinely of his or her due process and appeal rights in accordance with ODP policies. A participant will have his or her rights to file a fair hearing request discussed at least annually during the ISP annual review meeting and at any time the participant requests to change services or add new services.

The AE or ODP (for services that require prior authorization) is required to issue due process and appeal rights to the individual/ participant utilizing standard forms any time the following circumstances occur:

1.The individual, who is determined likely to meet an ICF/ID level of care and is enrolled in Medical Assistance, is not given the opportunity to express a service delivery preference for either Waiver-funded or ICF/ID services.

2.The individual is denied his or her preference of Waiver-funded or ICF/ID services.

3.Based on a referral from the AE or County Program, a Qualified Intellectual Disability Professional (QIDP) determines that the individual/participant does not require an ICF/ID level of care as a result of the level of care determination or re-determination process and eligibility for services is denied or terminated.

4.The individual/participant is denied his or her request for a new Waiver-funded service(s), including the amount, duration, and scope of service(s).

5.The individual/participant is denied the choice of willing and qualified Waiver provider(s).

6. A decision or an action is taken to deny, suspend, reduce, or terminate a Waiver-funded service authorized on the participant's ISP.

The AE or ODP is required to make all such notices in writing. Should the individual/participant choose to file an appeal, they must do so with the agency that made the determination being questioned. Title 55 Pa. Code §275.4(a)(2) states that individuals must file an appeal with the agency that made the determination being questioned, and §275.1(a)(3) specifically includes social service agencies: "the term Department includes, in addition to County Assistance Offices, agencies which administer or provide social services under contractual agreement with the Department."

It is the responsibility of the AE, ODP and in some cases the Supports Coordinator to provide any assistance the individual or participant needs to request a hearing. This may include the following:
•Clearly explaining the basis for questioned decisions or actions.

•Explaining the rights and fair hearing proceedings of the individual or participant.

•Providing the necessary forms and explaining to the individual or participant how to file his or her appeal and, if necessary, how to fill out the forms.

•Advising the individual or participant that he or she may be represented by an attorney, relative, friend or other spokesman and explaining that he may contact his local bar association to locate the legal services available in the county.

Certain Waiver actions related to level of care and Medicaid ineligibility are also subject to fair hearing and appeal procedures established through the local County Assistance Office (CAO). AE participation is expected in preparation for the hearing and at the hearing whenever the CAO sends a notice confirming the level of care determination and the individual or surrogate appeals that notice through the CAO. The AE will receive notice of the hearing from the Department.

In situations where services are denied without first being authorized in the ISP or for actions taken regarding waiver service delivery preference, the individual or participant is provided 30 days from the written notice mailing date to appeal the decision. The AE or ODP is required to provide an advance written notice of at least 10 calendar days to the participant anytime the AE initiates action to reduce, suspend, change, or terminate a Waiver service. The advance notice, which is sent by the AE or ODP, shall contain a date that the appeal must be received by the AE or ODP to have the services that are already being provided at the time of the appeal continue during the appeal process.

If the participant files an appeal (written or oral) within 10 calendar days of the mailing date of the written notification from the AE, the appealed Waiver service(s) are required to continue until a decision is rendered after the appeal hearing (55 Pa. Code § 275.4(a)(3)(v)(C)(I)). As noted above, the continuation language is included in the written notice that is sent to the participant by the AE or ODP. The postmark of a mailed appeal will be used to determine if the 10 day requirement was met by the participant or surrogate.

If the AE initiates an action on Waiver services and does not provide the written notice as required, the participant will have 6 calendar months from the effective date of the action to file an appeal. When this appeal is filed, services will be reinstated retroactively to the date of discontinuance and will continue until an adverse decision is rendered after the appeal hearing.

Fair hearing requests are collected in a statewide database and due process is monitored through the AE Oversight process.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution

process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The participant has the right to request an optional pre-hearing conference with the AE or ODP, as applicable (55 Pa. Code § 275.4(a)(3)(ii) [relating to Procedures]). The pre-hearing conference gives both parties the opportunity to discuss and attempt to resolve the matter prior to the hearing. Neither party is required to change its position. The pre-hearing conference does not replace or delay the fair hearing process.

In addition to pre-hearing conferences, service reviews are conducted by ODP for fair hearing requests for participants that relate to the denial, reduction, suspension, or termination of waiver services by the AE and do not require prior authorization. Service Reviews are used to ensure AE compliance with regulations, approved Waivers, the State Medicaid Plan and applicable Bulletins.

The AE must track decisions and timely implementation of the service review or Bureau of Hearings and Appeals decision ODP has established a database to track appeals submitted and the outcome.

Final orders issued by the Department's Bureau of Hearings and Appeals must be implemented within 30 calendar days of the final order if ruled in favor of the appellant. If there is continued failure to implement the service, the ODP regional office will notify the County Commissioners/AE Governing Board of the program's failure to provide waiver services in accordance with their Operating Agreement and require an immediate plan from the Commissioners/AE Governing Board to comply. Any further failure to implement the service will result in sanctions being imposed in accordance with the AE Operating Agreement.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

ODP is responsible for the operation of a grievance/complaint system.

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. 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).

ODP's grievance/complaint system is comprised of two main components. The first is a Customer Service line; the second is via email through the DPW website. Participants, family members and representatives, AEs, providers, advocates, and other interested parties may use these two components to ask questions, request information, or report any type of issue or complaint, including issues/complaints regarding AE performance. The Customer Service line (1-888-565-9435) is a general information line operated by ODP. The phone is located at ODP Headquarters and staffed by ODP personnel during normal business hours.

Individuals calling the Customer Service line with a complaint/grievance are logged into a database and the information is then referred to ODP regional, or headquarters staff for resolution. Documentation of the action and resolution is entered into the database by ODP. The second component of the grievance/complaint system is email.

The DPW website provides customers the option to "contact ODP," once a customer chooses this option they are directed to an email template which will be sent to ODP. The process for internet inquiries mirrors that of the Customer Service line calls. All internet inquiries are expected to be responded to within two business days. ODP is able to generate reports from the database about the types of Customer Service inquiries received and examines general patterns and trends.

In addition all ODP regional offices utilize a "duty officer" system whereby assigned staff are responsible for any complaints/grievances received directly at the regional office. Phone calls and letters are also received directly at ODP and responded to accordingly.

ODP's grievance/complaint system is neither a pre-requisite, nor a substitute for a fair hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical events are referred to as "incidents" in Pennsylvania's Regulations. The entities required to report critical events (or "incidents") are identified and defined in ODP Bulletin and Regulations and include: employees, contracted agents and volunteers of waiver service providers, Administrative Entities (AEs), and ODP staff. Participants and families are to notify the provider, when they feel it is appropriate, or their Supports Coordinator, regarding any health and safety concerns they may have related to a service or support they are receiving. ODP requires reporting of incidents on the web-based incident reporting system called the Home and Community Services Information System (HCSIS) whether the person who witnessed or first discovered the incident is an employee, contractor or volunteer.

ODP provides several avenues for direct reporting of incidents by volunteers, families or other community members. ODP provides a toll-free Customer Service Line to allow participants, families, or members of the community to report incidents and other concerns. If an incident is reported through ODP's Customer Service Line, the ODP Customer Service team records the information and communicates the information to the appropriate ODP regional office. ODP regional office staff ensures that an incident report is submitted if appropriate.

The Department of Public Welfare (DPW) website provides an email option and toll-free number, separate from ODP's Customer Service Line, through which members of the community can report concerns related to DPW offices, such as ODP. ODP enters any incidents reported via these avenues in HCSIS and treats them as any other incident. Regardless of an incident's reporting source, ODP requires documentation, tracking and investigation of all critical incidents.

Required reporters must report the following critical incidents within 24 hours of their occurrence or discovery. ODP requires investigation of critical incidents by an ODP-certified investigator in accordance with ODP's established timelines and standards. HCSIS requires the same manner of entry for all critical incidents and ODP ensures, regardless of the manner of the initial contact/notification of the incident, the entry of each reportable incident into HCSIS. Critical incidents include:

• Abuse, death, emergency room visit resulting from:
-Unexplained injury
-Staff to individual injury
-Injury resulting from Individual to Individual abuse
-Injury resulting from restraint

• Hospitalization resulting from:
-Accidental injury
-Unexplained injury
-Staff to individual injury
-Injury resulting from Individual to Individual abuse
-Injury resulting from restraint

• Individual to Individual abuse, sexual

• Injury requiring treatment beyond first aid:
-Staff to individual injury
-Resulting from Individual to Individual abuse
-Resulting from a restraint

• Misuse of funds

• Neglect

• Rights violation

Exploitation may be reported within the categories of abuse, misuse of funds, and rights violation rather than as a discrete category.

Required reporters must also report the following incidents within 24 hours of their occurrence or discovery. Although a certified investigation is not required for the following incidents, there is a requirement for a review by ODP and the AEs within specified timeframes. They are reviewed within 24 hours by both the AE and the ODP regional offices to ensure that there was prompt action taken to protect the participants' health, safety and rights. The incident is again reviewed by both offices once the report has been finalized by the provider, at which time they are either approved or not approved. Any deficiency with the handling of the incident by the provider will be addressed with the provider by the AE and/or ODP to ensure the health and welfare of the participant(s) and to ensure that appropriate procedures were followed.
• Suicide attempt

• Hospitalizations that do not involve:
-Accidental injury
-Unexplained injury
-Staff to individual injury
-Injury resulting from Individual to Individual abuse
-Injury resulting from restraint

• Psychiatric hospitalization

• Emergency room visits that do not involve:
-Unexplained injury
-Staff to individual injury
-Injury resulting from Individual to Individual abuse
-Injury resulting from restraint

• Individual to Individual abuse that does not involve sexual abuse

• Missing person

• Injury requiring treatment beyond first aid that does not involve:
-Staff to individual injury
-Resulting from Individual to Individual abuse

• Disease reportable to the Department of Health

• Fire

• Law enforcement activity

• Emergency closure (of a facility or home)

Required reporters must report the following incidents within 72 hours of their occurrence or discovery. Certified investigation is not required.
• Medication error

• Restraint (unless involving emergency room visit, hospitalization or abuse).

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Supports Coordinators deliver and discuss information concerning protections from abuse, neglect, and exploitation, including how to notify appropriate authorities. Each waiver participant receives a document prepared by ODP that includes contact information for Supports Coordinators, authorities, family members, advocacy organizations and others. Waiver participants, families, and/or legal representatives can use this information as needed to report concerns regarding abuse, neglect, and exploitation. The document includes ODP's toll-free Customer Service Line number. This information shall be discussed at least annually and or more frequently as determined necessary by the Supports Coordinator and at the request of a participant or caregiver.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

ODP receives and evaluates reports on each type of critical incident (identified in Item G-1-a). When a critical incident is recognized or discovered, prompt action must be taken to protect the participant and file an incident report in the web-based Home and Community Services Information System (HCSIS) Incident Management System within 24 hours.

In accordance with the ODP policy on Incident Management, within 24 hours of an incident report being submitted, designated staff from both the AE and ODP Regional Office evaluates the report to ensure that:
• The provider took prompt action to protect the participant's health, safety and rights. This may include, but is not limited to dialing 911, arranging medical care, separating the perpetrator, arranging counseling or referring to a victim assistance program.

• If applicable, the provider met the notification requirements of 35 P.S. §§ 10225.101 -10225.5102 and 23 Pa. C.S. §§6301-6384 (relating to The Older Adults Protective Services Act and Child Protective Services Law).

• The provider notified the family of the incident within 24 hours (unless otherwise indicated in the individual support plan).

• The provider initiated an investigation by assigning the case to a Certified Investigator (CI).

ODP requires that providers separate the victim from the alleged perpetrator (also known as the "target" of the investigation) when the victim's health and safety is jeopardized. Separation may include reassigning, suspending or terminating the alleged target. An additional safeguard for participants over age 60 is Pennsylvania's Older Adults Protective Services Act, which requires suspension of the alleged target if the victim's health and safety are jeopardized. ODP also complies with Pennsylvania's ACT 28/26, which requires reporting the abuse of care-dependent persons to the Attorney General and/or the local District Attorney.

ODP prefers not to impose change upon the victim unless that is his or her choice or there are no other alternatives. When incidents involve targets who cannot be separated, ODP will remove the victim from the environment in order to achieve separation.

When a participant who is residing with his or her family experiences a critical incident that jeopardizes the victim's health and safety, the provider, AE or ODP will seek the assistance of law enforcement, Child Protective Services, or the Office of Aging, who have the authority to remove the alleged perpetrator or the victim from the home to ensure safety.

ODP certifies its investigators and requires that only those certified by ODP conduct investigations of critical incidents. ODP requires CIs to participate in four (4) days of training in investigatory procedures. ODP only certifies participants who successfully complete the training and pass a final examination. ODP requires recertification every three (3) years.

CIs follow the protocol established in the ODP policy on certified investigations.

Investigators accommodate the witness's communication needs as appropriate and conduct interviews individually, and in a private place, if possible. If the witness requires the presence of a third party, the CI must arrange for third party representation (i.e. a staff person or family member).

When the CI completes the investigation, he or she enters the summary into HCSIS. The provider then completes and finalizes the report within 30 days of the incident, HCSIS sends an electronic alert notifying ODP and the AE of the finalized report.

The AE evaluates all finalized reports within 30 days and approves the report if:
• The appropriate action to protect the participant's health, safety and rights occurred;

• The incident was correctly categorized;

• Timely completion of the certified investigation occurred;

• The investigation summary supports the conclusion;

• There was placement of proper safeguards;

• There was corrective action in response to the incident that has taken, or will take place;

• Steps were taken by the provider in response to the investigation's conclusions;

• Changes were made in the participant's plan of support necessitated by or in response to the incident;

• The anticipated date of completion of any corrective action that cannot/has not been completed before finalization;

• The participant or participant's family received notification of the findings, unless otherwise indicated in the individual plan, by the entity conducting the investigation. This notification is documented in the finalized incident report; and

• Incidents of abuse, neglect and exploitation were reported to the appropriate authority as required by Pennsylvania Law.

The AE disapproves reports that fail evaluation. Disapproved reports revert to the provider, who corrects any deficiencies and resubmits the report for re-evaluation. The AE will continue to work with and monitor the provider to ensure appropriate adherence to the established policies. ODP Regional Office staff evaluates approved reports within 30 days and, if satisfactory, closes the incident report.

Methods for Detecting Unreported Incidents
ODP reviews waiver participant records through the AE Oversight and Monitoring Process (AEOMP) and identifies if a critical incident has been unreported. If an unreported incident is discovered, the AEOMP reviewer communicates this finding immediately to the AE who is required to ensure that an incident report is filed and appropriate action is taken.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

ODP is responsible for the oversight of and response to critical incidents. ODP evaluates all finalized reports, and completes a management review within 30 days after the AE approves the incident report. This oversight occurs on an

ongoing and annual basis.

Each regional office also reviews significant events during monthly Risk Management Workgroup meetings. The Risk Management Workgroup provides the AE or provider technical assistance when a need is identified.

As a related activity to the provider and AE oversight processes, ODP conducts a review of incident management reports on both a provider and AE specific level. Through the use of this information, ODP completes an analysis of aggregate incident data to identify patterns and trends statewide and regionally as described in Appendix H. ODP identifies factors that put people at risk and recommends appropriate interventions and improvement activities.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ODP promotes a philosophy of “positive approaches” which focuses on eliminating restrictive and aversive procedures, helping participants maintain contacts with family and friends and supporting participants in becoming an interactive part of the community. A positive approach assumes that all behavior has meaning and that a participant’s behavior can be a method to communicate needs and wants or the manifestation of some clinical issues.

Because ODP’s primary efforts are aimed at a diversity of positive approaches that enhance participants’ lives, ODP requires providers of all Home and Community Based services to use restraints only as a last resort emergency response to protect the participant’s safety. ODP requires all providers to report via HCSIS all use of restraints. Providers report the use of authorized restraints on HCSIS under the restraint category. ODP categorizes unauthorized use of restraints with the primary category of Abuse and a secondary category of Unauthorized Use of a Restraint. Abuse, including that involving restraints, is a critical incident and requires investigation and review at the AE and Regional levels.

ODP prohibits the following types of restraints in all settings. The use of these prohibited restraints would be reported on HCSIS as a rights violation, abuse, or neglect regardless of the setting.

• Seclusion: Seclusion is defined as placing a participant in a locked room. A locked room includes a room with any type of engaged locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.

• Chemical: Chemical restraint is a drug used to control acute, episodic behavior that restricts the movement or function of a participant and is not a standard treatment for the participant’s medical or psychiatric diagnosis.

-When a physician orders a medication that is part of the ongoing individualized plan and has

documented as such for treating the symptoms of mental illness, the medication is not considered a chemical restraint. The use of Pro Re Nata (PRN) medication will be done in accordance with State prescribed procedures which includes development of a post review protocol by the provider's quality improvement/risk management committee to ensure that use of the medication was consistent with the Bulletin's expectations.

• Mechanical: Mechanical restraint is a device used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body. Examples of mechanical restraints include anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, poesies, waist straps, head straps, restraining sheets and similar devices. When a physician orders a mechanical device to protect the individual from possible harm following surgery or an injury, it is not a mechanical restraint. Examples of mechanical devices that are not restraints include a device used to provide support for functional body position or proper balance and a device used for medical treatment, such as sand bags to limit movement after medical treatment, a wheelchair belt that is used for body positioning and support or a helmet for prevention of injury during seizure activity, are not considered mechanical restraints.

•Prone position manual restraints

ODP permits the following types of restraints when the conditions outlined below are met. When restraints are used they are reported on HCSIS and categorized as a restraint.

Manual restraints, commonly referred to as physical restraints, are permitted and used only as a last resort safety measure when the participant is in imminent danger of harming oneself and/or others and other measures are ineffective.

Manual restraints that inhibit the respiratory or digestive system, involve compliance through the infliction of pain, hyperextension of joints, pressure on the chest or joints, or that involve the use of 'takedown' techniques in which the participant is not supported and allow for free fall as the participant goes to the floor are not permitted.

Mechanical restraints are permitted when they include the use of helmets, mitts and muffs to prevent self-injury on an interim basis. If a mechanical restraint is used, the following apply:
• The use of a mechanical restraint may not exceed 2 hours, unless a licensed physician examines the participant and gives written orders to continue the use of the restraint. Reexamination and new orders by a licensed physician are required for each 2-hour period the restraint is continued. If a restraint is removed for a purpose other than for movement and reused within 24 hours after the initial use of the restraint, it is considered continuation of the initial restraint.

• A licensed physician shall be notified immediately after a mechanical restraint is used.

• The restraint shall be checked for proper fit by staff at least every 15 minutes.

• Physical needs of the participant shall be met promptly.

• The restraint shall be removed completely for at least 10 minutes during every 2 hours the restraint is used.

• There shall be training for the participant aimed at eliminating or reducing the need for the restraint in the future.

During licensing surveys, the Department validates that restraints, if administered, were applied in accordance with requirements.

Through review of the incident and ISP, ODP carefully monitors both the use of approved restraints and the procedures used when or if such methods were employed. This process is also used to ensure that no providers have utilized the prohibited practices of seclusion or prone position manual restraint.

ODP/DPW is clear on its mission to eliminate restraints as a response to challenging behaviors. ODP has issued a bulletin that discusses strategies related to the reduction and eventual elimination of restraint. ODP expects providers to utilize these strategies to develop policies and procedures that outline specific steps for eliminating restraints in any ISP as well as general policies and procedures promoting the goal

of restraint elimination. Providers are responsible for training staff in restraint policy, the use of restraints, methods for reducing restraints and the use of positive approaches, with the ultimate goal of restraint elimination.

USE OF ALTERNATIVE METHODS BEFORE INSTITUTING RESTRAINTS AND PROTOCOLS
Physical restraint is always a last resort emergency response to protect the participant's safety. Consequently, it is never used as a punishment, therapeutic technique or for staff convenience. The participant is immediately to be released from the restraint as soon as it is determined that the participant is no longer a risk to him/herself or others. Additionally, regulations specifically state "every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures". ISPs identify strategies to avoid the need for restraints. These plans identify the antecedents, thereby enhancing opportunity to intercede before the use of restraint is needed.

METHODS FOR DETECTING UNAUTHORIZED USE OF RESTRAINTS
ODP detects unauthorized restraints or misreported use of restraints through the various oversight and monitoring processes, as well as through communication with the broader community (including through the customer service line and advocacy organizations). As these situations are identified, ODP and AEs, require providers to report the discovered restraint incidents and, if application of the restraint did not follow ODP standards, to report the incident as abuse. These incidents are reported and investigated following established procedures.

The AEs and ODP review each unauthorized restraint through the incident management process. Providers report any unauthorized use of a restraint via HCSIS. Incidents where an unauthorized use of a restraint may have occurred are categorized with a primary category of Abuse and a secondary category of Unauthorized Use of a Restraint. All incidents of abuse are critical and require investigation.

When providers apply restraints contrary to ODP standards, they are incidents of abuse and require investigation. Part of the incident management process is making corrective actions based on discoveries made during the investigation. The AE and regional levels review investigation findings and corrective actions to ensure that the corrective actions are appropriate. If the corrective actions are insufficient, the AE or region disapproves the report until the provider makes full corrective actions. In the case of abusive restraint, corrective actions often include additional training and developing a restrictive procedure plan for the participant.

ODP has several methods in place to assist providers in restraint elimination. ODP requires providers to implement risk management strategies to prevent, reduce and manage the severity of incidents, including restraints. Steps in risk mitigation include identifying: risk factors of the participant; health status, family medical history and medical risks; medication history and current medication; behavioral history and behavior risks; incident history; social environment needs; physical environment needs; personal safety; identify strategies to reduce the frequency of incidents or reduce the severity of associated effects; train the participant and employees on the risk factors and risk mitigation strategies; implement preventive measures to reduce the level of risk of an incident or negative outcome from occurring; monitor participant's risk mitigation strategies and update the strategies.

ODP strongly encourages debriefing sessions following the use of correctly applied restraints. While debriefing is not required, it is one of the methods/strategies available to fulfill the anticipated regulatory risk mitigation requirements. Other best practices will be conveyed to waiver providers in an upcoming manual geared to supporting participants with a dual diagnosis and technical assistance available from the HCQUs. These sessions address the needs directly following a restraint where events and strategies are discussed in greater depth and detail. The debriefing sessions should work to address trauma and minimize the negative effects of the use of restraint while addressing the following components:
• Thorough analysis of the events that occurred before, during and after each incident.

• Strategies to prevent or decrease the time of future restraints

• Skills or methods to prevent a future crisis.

• Appropriate additions, deletions, or modifications to a participant's ISP, including recommendations and outcomes.

RESTRAINT AUTHORIZATION
A report and investigation of any restraint determined to be improper or unauthorized is required. Any

restraint not approved in the ISP or one that is not a part of an agency's emergency restraint (unanticipated and arising out of an unexpected situations not previously accounted for in an individualized plan of care) procedure is considered unauthorized. A restraint that is intentionally applied incorrectly is considered an improper use of restraints.

Licensing regulations for licensed residential services and adult training facilities outline the requirements related to restraints. When the same participant experiences a restraint twice in a 6-month period, a behavior support plan must be developed, reviewed and approved before any additional restraints are implemented for that person.

See Main 8B for remainder of response.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

ODP oversees the use of restraints through AEOMP and provider monitoring. State regulations governing licensed programs require that a restrictive procedure plan is written and approved prior to the use of any restraint and then only to ensure the health and safety of a participant. The only exception to using a restraint without an approved plan is when the restraint is used for the first time during an emergency situation in order to protect the health and safety of a participant. As part of the Department's annual licensing inspections, licensing staff reviews incidents prior to licensing visits to identify participants who have been restrained and to verify restrictive procedure plan regulations have been met. Providers that frequently use restraints are provided technical assistance, training and other resources needed to decrease the use of restraints.

Discoveries are also made through the customer service line and advocacy organizations. As these situations are identified, ODP requires the provider to report unreported incidents of restraint and, if application of the restraint did not follow ODP standards, to report the incident as abuse and investigate the situation following established procedures.

ODP also conducts oversight through electronic reporting. ODP requires all providers to report, via HCSIS, any use of a restraint within 72 hours of occurrence or discovery. Improperly applied restraints are reported as critical incidents of abuse within 24 hours of occurrence or discovery. The AE and region review the initial report of critical incidents within 24 hours of the providers' submission. As a critical incident, abuse involving restraints requires investigation within 30 days of occurrence or discovery. The AE reviews the outcome of the investigation and corrective actions within 30 days of the provider finalizing the report. The regional reviews both the provider's and the AE's findings within 30 days of the AE approving the report.

ODP conducts ongoing oversight of the use of restraints through the risk management. ODP Regional risk management committees monitor the incidence of restraint applications during their monthly regional meetings. Action plans are developed including strategies intended to remediate and/or improve outcomes for participants. Restraint data is gathered monthly and displayed in a central location for Office-wide use. This data set includes the number of restraint incidents; the number of unique participants restrained; and identifies participants and providers with high frequency of restraints. These data are available to inform regional and AE efforts in assisting providers to approach services positively. The regional Community Services Quality Oversight Groups examine regional data quarterly and compile their findings for a statewide Community Services Quality Oversight Group discussion of restraints. Abuse incidents, which include a secondary category of unauthorized use of restraints, are also discussed at both regional and statewide Community Services Quality Oversight Groups.

Patterns of restraints such as identifying participants who have a high number of restraints or identifying providers that frequently use restraints are addressed using a number of different strategies. The participant may be referred by the AE to the local HCQU for a clinical review, evaluation, and further recommendations. Individual remediation such as the identification of reasons for behaviors leading to restraint and the selection of alternative approaches to address the participant's needs is an example of a result of such a review.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

(2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ODP promotes a philosophy of "positive approaches" which focuses on eliminating restrictive and aversive procedures, helping participants maintain contacts with family and friends and supporting participants in becoming an interactive part of the community. A positive approach assumes that all behavior has meaning and that an participant's behavior can be a method to communicate needs and wants or the manifestation of some clinical issues. ODP crafted the Individual Support Plan format around the following positive approaches activities to ensure universal implementation:
• Positive Approaches requires getting to know each participant, his or her unique qualities as well as his or her personal history.

• Positive Approaches requires that all people involved are comfortable enough to speak freely, that we all listen carefully and respectfully, that we take each person seriously, and finally, that we honor what we hear.

• Positive Approaches requires an examination of all aspects of the participant's life including each participant's living environment, relationships, activities and personal dreams.

• Positive Approaches integrates values, philosophies, and technologies. Its purpose is to support participants to grow and develop, to make their own decisions, to achieve their personal goals, to develop relationships, and enjoy life as full members of the community.

• Positive Approaches encourages us to see clearly and honestly the good reasons and adaptive qualities of even the most troubling behavior.

• Positive Approaches focuses not on fixing the participant, but on building competencies, creating opportunities and offering choices that help each participant live a fulfilling life.

• Positive Approaches assumes that all behavior has meaning and that a participant's behavior can be a method to communicate needs and wants or the manifestation of some clinical issues.

Because ODP's primary goal is a diversity of positive approaches that enhance participants' lives, ODP requires providers of all Home and Community Based service, regardless of licensure, to use restrictive interventions only within approved guidelines (see below). ODP requires all providers to report the use of a restrictive intervention that does not follow ODP guidelines. Providers report restrictive interventions via HCSIS as neglect or as rights violation. Providers report neglect and rights violation on HCSIS. ODP categorizes incidents of neglect and incidents of rights violations as critical and requires investigation and review at the AE and Regional levels.

APPROPRIATE USE OF RESTRICTIVE INTERVENTIONS
Providers must make every attempt to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures. ODP developed the Individual Support Plan to help

understand a participant's challenging behavior, identify antecedents to, and methods for de-escalation. ISPs guide delivery of supports and help staff to recognize and react to situations on an individual basis. ODP monitors review ISPs and providers' policies and procedures. Reviewers recommend improvements for using the ISP if providers use it ineffectively. The ISP includes:
• The participant's likes and dislikes;

• Personal strengths and interests;

• Known antecedents to challenging behavior;

• Strategies for helping the participant de-escalate (i.e. an opportunity for alone time, engaging in a satisfying activity, providing a supportive environment that allows the participant to talk about his or her feelings)

Permitted Restrictive Interventions Restrictive interventions/procedures other than restraints may include:

• Token economies or other reward and/or level systems as part of programming.

• Environmental restrictions, for example, limiting access to food for participants diagnosed with Prader Willi.

• Intensive supervision such as 1:1 or 2:1 staffing levels or higher, for purposes of behavior monitoring/intervention/redirection.

• Anything that a person is legally mandated to follow as part of probation or a court restriction that is superseded by our regulation and other ODP policy. The individualized planning process accounts for court orders and legally mandated restrictions. When legally mandated restrictions conflict with ODP policy, the provider requests a waiver from that policy in order to comply with the restrictions.

• Exclusions are permitted as follows:
-Exclusion is the removal of a participant from the participant's immediate environment and restricting the participant alone to a room or area. If a staff person remains with the participant, it is not exclusion.

-Exclusion shall be used only when necessary to protect the participant from self-injury or injury to others.

-Exclusion shall be used only when it has been documented that other less restrictive methods have been unsuccessful in protecting the participant from self-injury or injury to others.

-A participant shall be permitted to return to routine activity within the time specified in the restrictive procedure plan not to exceed 60 minutes within a 2-hour period.

-Exclusion may not be used for a participant more than 4 times within a 24-hour period.

-A participant in exclusion shall be monitored continually by a staff person.

-A room or area used for exclusion shall have at least 40 square feet of indoor floor space, with a minimum ceiling height of 7 feet.

-A room or area used for exclusion shall have an open door or a window for staff observation of the participant.

-A room or area used for exclusion shall be well lighted and ventilated.

NOTE: Exclusion differs from Seclusion (defined below) in several ways. Exclusion provides privacy, which allows the participant time and space to regroup. It may involve going for a walk, going to a private space (other than the personal bedroom), or going out in the yard. Exclusion does not specifically involve a room but focuses more on a separation from stimuli. Participants may choose to remove themselves from an exclusionary exercise at any time. Seclusion, in comparison, is punitive and, because it involves locked doors, does not provide participants latitude to remove themselves from the exercise. Exclusion is allowable but seclusion is considered abuse or a violation of rights.

ODP strongly discourages the use of restrictive interventions. If restrictive interventions are applied they must conform to the following in order to be permitted:
• A restrictive procedure may not be used as retribution, for the convenience of staff persons, as a substitute for the program or in a way that interferes with the participant's developmental program. Restrictive procedures may only be employed as a last resort.

• A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.

ODP prohibits the following types of restrictive interventions:
• The use of aversive conditioning; defined as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful or noxious stimuli, is prohibited.

• Seclusion, defined as placing a participant in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.

• A participant's personal funds or property may not be used as reward or punishment. A participant's personal funds or property may not be used as payment for damages unless the participant consents to make restitution for the damages.

PROTOCOLS FOR AUTHORIZING THE USE OF RESTRICTIVE INTERVENTIONS, INCLUDING TREATMENT PLANNING AND REVIEW/AUTHORIZING PROCEDURES.
Prior to a restrictive procedure being employed a restrictive procedure review committee must approve the use. The restrictive procedure review committee shall include a majority of persons who do not provide direct services to the participant and is convened by the provider. The committee establishes time frames for review and revision of the restrictive procedure plan, not to exceed 6 months between reviews. The committee will ensure that the restrictive procedure plan includes the types of restrictive procedures that may be used and the circumstances under which the procedures may be used, the specific behavior to be addressed and the suspected antecedent or reason for the behavior, and outcome desired stated in measurable terms. Methods for modifying or eliminating the behavior, such as changes in the participant's physical and social environment, changes in the participant's routine, improving communications, teaching skills and reinforcing appropriate behavior will also be included in the plan and reviewed by the committee.

METHODS FOR DETECTING UNAUTHORIZED USE OF RESTRICTIVE INTERVENTIONS
When providers apply restrictive interventions without following ODP requirements, they are incidents of neglect or rights violation and require reporting on HCSIS, review by the AE and ODP, and investigation following ODP standards. Part of the investigatory process is making corrective actions based on discoveries made during the investigation. The AE and regional levels review the investigation, findings, and corrective actions to ensure that the corrective actions are appropriate. If the corrective actions are insufficient, the AE or region disapproves the report until the provider makes full corrective actions, which, in the case of unauthorized use of restrictive intervention, often includes additional training.

ODP also detects unauthorized use of restrictive interventions through the various oversight and monitoring processes, as well as through communication with the broader community (including through the customer service line, advocacy organizations, and reporting through the DPW website). As these situations are identified, ODP and the AEs, require the provider to report incidents involving unauthorized use of restrictive interventions as neglect or rights violation. Each of these is considered a critical incident and requires investigation following established procedures.

Supports Coordinators review incidents reported and meet with the participant in various settings for a specific number of times per year depending upon the waiver type. During these monitoring visits, they meet the participant in various settings and observe their interactions with staff and others. If restrictive procedures are observed and there is no restrictive procedure plan in place, the Supports Coordinator must report this as an incident in HCSIS and follow through with the provider to assure that a restrictive procedure plan is developed before any additional restrictive procedures can be applied.

REQUIRED DOCUMENTATION (RECORD KEEPING) WHEN RESTRICTIVE INTERVENTIONS ARE USED
A record of each use of a restrictive procedure documenting the specific behavior addressed, methods of

intervention used to address the behavior, the date and time the restrictive procedure was used, the specific procedures followed, the staff person who used the restrictive procedure, the duration of the restrictive procedure, the staff person who observed the participant if exclusion was used and the participant's condition during and following the removal of the restrictive procedure shall be kept in the participant's record.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

ODP is the state agency responsible for monitoring and overseeing the use of restrictive interventions. ODP employs several methods for overseeing restrictive interventions and monitoring their frequency.

One method of oversight is through electronic reporting. ODP requires providers of all Home and Community Based services, regardless of whether the services provided require licensure, to use restrictive interventions only within approved guidelines (see below). ODP requires all providers to report the use of a restrictive intervention that does not follow ODP guidelines. These incidents are reported via HCSIS as neglect or as rights violation. Providers report neglect and rights violation on HCSIS. ODP categorizes neglect and rights violations as critical incidents and requires investigation and review at the AE and Regional levels.

Another method for oversight is through ODP's monitoring process, including AEOMP, provider monitoring, and licensing. As part of ODP's annual licensing inspections, licensing staff reviews records, and, when the record indicates that the provider applied restrictive interventions contrary to ODP requirements, the provider must enter the incident on HCSIS as neglect or a rights violation.

Discoveries are also made through the customer service line, advocacy organizations, or the DPW website. As these situations are identified, ODP requires the provider to report incidents when restrictive interventions did not follow ODP standards.

ODP also conducts ongoing oversight of the use of unauthorized restrictive interventions. ODP Regional risk management committees monitor the incidence of neglect and rights violations. The regional Community Services Quality Oversight Groups examine regional data quarterly and compile their findings for a statewide Community Services Quality Oversight Group discussion of restraints. Incidents of neglect and rights violation are also discussed at both regional and statewide Community Services Quality Oversight Groups.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- **The State does not permit or prohibits the use of seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

- **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

  i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Healthcare practitioners are the first line in monitoring participant medication regimens. As the people who prescribe the medications, they ensure that the medication regimen meets the participant's diagnosed condition, that none of the medications conflict and that the doses are prescribed correctly.

The second line medication monitoring occurs through Supports Coordinator review of the participant's services to ensure that all programs are administering medications appropriately. For participants that take medication, their Supports Coordinators review medication regimens during each face-to-face monitoring visit using the ISP monitoring tool which lists the medication that the participant takes; the reason for the medication; the total daily dose; whether or not blood levels are necessary; and what the medication is supposed to do. Monitoring to detect potentially harmful practices related to medication occurs for all waiver participants that take medication. The elements of the tool designed to do this include: looking at the completeness and correctness of medication administration documentation; efficacy of medication; knowledge of side effects and strategy to report; changes in medications or presence of side effects; changes in health that might be related to medication; and appropriate and timely communication about health issues between medical practitioners and the participant's team. Supports Coordinators also document allergies including those to medications in the ISP. The ISP monitoring tool is used to monitor medication given at home including a licensed, residential setting, and a day program. Monitoring of medication occurs three times a quarter in different locations. Participants that are prescribed behavior modifying medications are required to have their medication reviewed by the prescribing psychiatrist at least every 3 months. Supports Coordinators ensure these reviews are occurring during each face-to-face monitoring visit.

If concerns or issues related to medication administration are discovered at a face-to-face monitoring visit, the Supports Coordinator can seek assistance from the Health Care Quality Units (HCQUs) or regional nurses to perform a medication review so that strategies can be developed to address the concerns or issues. Both the regional Nurses and the HCQUs are available for targeted training and technical assistance with regard to questions about medications and their administration. All HCQUs provide training and outreach to SCOs and AEs on a regular basis.

Department licensing also monitors medication and medication administration. Providers with licensed sites are monitored using a sampling strategy. Licensing personnel look at trainer and medication administrator certification as well as medication regimens on Medication Administration Records as compared to the

physician documentation to assure consistency between the two. As well they compare allergies and unusual reactions to medication to the medication list to detect any use of contraindicated medications. ODP nurses may be involved when medication regimens are complex or licensing personnel have questions about the implementation of the medication course to provide clinical input.

Regional nurses also participate in second line monitoring. Regional nurses often conduct medication reviews when they are working with a provider to address other issues or complaints when received. Reviews of medications for participants, particularly those with complex medication regimens or behavior modifying medications as part of their treatment program, can occur through a number of methods, including discussions with ISP team members; training sessions with the HCQUs related to how to look at medications related to medical and behavioral conditions; and based on issues and concerns noted during monitoring.

ODP uses the DPW Medication Administration Program to teach unlicensed staff to give medication to participants using a standard curriculum. Many of the provider agencies have nurses. Some of the nurses become trainers and monitor medication through the course, while others provide oversight within the agency for medication administration and health issues. The course requires periodic reviews of staff performance to maintain certification. These include reviews of Medication Administration Records or logs for each staff member administering medications. The review of medication administration logs for errors in documentation includes matching the participant's prescribed medications on the log to those available to be given. Maintenance of certification requires review of 4 Medication Administration Records and two observations of passing medication and documentation. Providers are to use Medication Administration Records from different participants when completing the reviews so that each of the participants' medication regimens are reviewed across the year. As well the course teaches staff to review medication when it is received from the pharmacy and compare it to the Medication Administration Records, thus providing a regular review of medications by provider staff. Part of the documentation and checks include looking at medication allergies for the possibility of a contraindicated drug.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

ODP nurses not only teach the medication administration course, but also monitor the provider activities around medication administration and the performance of the provider trainers in order to assure safety and maintain the integrity of the program. These reviews occur periodically and usually in response to either a problem related to licensing surveys or a request from the provider because of issues at the agency. A formal checklist is employed for providers where the ODP nurses evaluate their program. The nurses also may provide technical assistance with respect to medication errors and the implementation of the medication program. They, then follow-up on these recommendations and any plans of correction required by licensing related to medication administration to assure that the potentially harmful practices are remedied. Follow-up occurs by visiting the provider site and either observing the medication administration training or reviewing charts to assess the changes in practice. In addition to this the HCQUs have developed standard guidance for providers regarding medication administration policies and procedures to supplement what is in the standard course and provide technical assistance regarding medication administration and implementing changes to prevent errors.

Despite ODP's extensive medication administration course, medication errors sometimes occur. ODP requires providers to report medication errors via HCSIS within 72 hours of occurrence or discovery. Medication error reports utilize a root cause analysis approach which asks the reporter to answer the following questions, including describing the immediate remediation action taken, "What happened?" "Why did the error occur?" "What was the response?" "What will the agency do to prevent further errors?" This approach also informs the curriculum offered in the medication management course and allows for process improvement.

If a medication error is the result of a critical incident, such as neglect or results in a critical incident, such as death, then it is not reported as a medication error but rather as the higher level critical incident. The incident is then subject to investigation and AE and regional review.

Medication error reporting data is aggregated, analyzed and discussed at ODP's Community Services Quality Oversight Group. Examples of performance data that are reviewed and analyzed for opportunities to design and implement system improvements include aggregate discovery and remediation data demonstrating compliance with waiver assurances, risk management data, including total numbers of critical incidents, by type, total numbers of restraints, medication errors and deaths by cause, and financial management information

including service and payment claims data.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State regulations for community homes and day programs allow for the administration of medication by unlicensed staff when trained using a standard Medication Administration course. Licensed nurses are not required to take the administration course as this is part of their clinical scope of practice under the State Nursing Board. Self-administration guidelines appear in the regulations and setting-up and monitoring self-administration programs are taught as part of the medication administration program. These requirements do not apply to non-licensed providers.

iii. Medication Error Reporting. *Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  The Department of Public Welfare, Office of Developmental Programs via an electronic database, HCSIS which is accessible by the state, AEs, Supports Coordinators and providers.

  (b) Specify the types of medication errors that providers are required to *record:*

  There are no types of medication errors that providers are required to record, but not report.

  (c) Specify the types of medication errors that providers must *report* to the State:

  Providers report medication errors as specified in the Incident Management module of HCSIS including wrong person, wrong medication (wrong medication, extra dose, and discontinued medication), wrong dose, wrong route, wrong time, wrong form, wrong technique/method, and wrong position.
- ○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

ODP monitors performance of providers in the administration of medication to waiver participants both directly and indirectly. As described in section G-3bi, direct monitoring occurs through annual Department licensing reviews and periodically by the nurses that teach the course. In addition, the AEOMP indirectly evaluates individual waiver participant's medication information. Each AE is monitored by reviewing a sample of waiver participants' records. Direct monitoring occurs when the AEs and Supports Coordinators monitor medications for participants. Supports Coordinators monitor medication administration and practices in the manner described in G-3bii. AEs monitor the performance of Supports Coordinators and review medication errors through their risk management processes including evaluating the information about how the errors occurred in order to intervene with a provider that shows poor medication administration practices. Health Care Quality Units (HCQUs) also provide indirect monitoring of medication administration through their individual case and provider reviews. When HCQUs, Supports Coordinators, and AEs review medications, the results are communicated to ODP in a number of ways. Provider issues related to implementation of the Medication Administration course are referred to the nurses or the Medical Director to be addressed either at the level of the provider or the level of the course. Licensing documents findings in their licensing reports, but also communicates any issues around the implementation of the course to the nurses and the Medical Director by phone, email or in person.

The reporting strategy for medication errors facilitates a root cause analysis on the part of the provider related to each specific medication error. Problems with specific providers regarding medication administration practices are remediated in a number of ways. The nurses from ODP provide technical assistance to the providers around their medication practices especially those that are identified as being unsafe or problematic. The medication administration course itself includes a set of standard remediations for medication administrators that have made errors in order to assure that they know how to properly administer and document related to that particular situation. The HCQUs provide training and technical assistance to providers on an ongoing basis to promote the use of best practices around medication administration.

The required medication administration course teaches problem solving and has been modified to address problems identified through data captured in HCSIS. The HCQUs, AEs, and regional risk management committees review medication errors on a regular basis. ODP reviews reports submitted by the AE. The AE reviews reports submitted by providers. Any medication error resulting in a critical incident requires investigation. ODP reviews lead to changes in the medication administration instrument and additional training. Health Alerts are issued and distributed widely on specific drug issues.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*
   i. **Sub-Assurances:**
      a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.1. Number and percent of critical incidents in which prompt action (demonstrated within 24 hours) is taken to protect the participant's health, safety and rights. Percent = number of critical incidents in which prompt action is taken to protect the participant's health, safety and rights/number of critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Management Log

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.2. Number and percent of AEs that reviewed incidents within 24 hours of the report. Percent = number of AEs that reviewed incidents within 24 hours of the report/number of AEs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.3 Number and percent of critical incidents finalized within the required time frame. Percent = number of critical incidents finalized within the required time frame/all critical incidents, by type of incident.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.4. Number and percent of AEs that completed investigations in accordance with ODP standards. Percent = number of AEs that completed investigations in accordance with ODP standards/number of AEs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.5. Number and percent of critical incidents, confirmed, by type. Percent = number of critical incidents, confirmed, by type/all critical incidents confirmed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.6. Number and % of confirmed critical incidents where corrective actions were carried out or planned by the appropriate entity within the required time frame. Percent = number of confirmed critical incidents where corrective actions were carried out or planned by the appropriate entity within the required time frame/number of confirmed critical incidents where corrective actions were required.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

a.i.7. Number and percent of waiver participants who received information about reporting abuse, neglect, and exploitation. Percent = number of waiver participants who received information about reporting abuse, neglect, and exploitation/number of waiver participants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.8. Number and percent of AEs that maintain documentation of incident management training. Percent = number of AEs that maintain documentation of incident management training/number of AEs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.9. Number and percent of waiver participants for whom there was an unreported critical incident, by type. Percent = number of waiver participants for whom there was an unreported critical incident, by type of incident/number of waiver participants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
AEOM Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate, representative random sample Confidence interval: +/-5 Confidence level: 95%
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.10. Number and percent of deaths, by cause of death. Percent = number of deaths, by cause of death/all deaths.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Mortality Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.11. Number and percent of deaths of waiver participants examined according to State protocols. Percent = number of deaths of waiver participants examined according to State protocols/number of deaths of waiver participants requiring examination according to State protocols.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Mortality Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

a.i.12. Number and percent of incidents of restraint where proper procedures were followed, by type of restraint. Percent = number of incidents of restraint where proper procedures were followed, by type of restraint/number of incidents of restraint, by type of restraint.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.13. Number and percent of medication errors, by type. Percent = number of medication errors, by type/all medication errors.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.14. Number and percent of complaints, by type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Log

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.15. Number and percent of complaints resolved within 21 days of receipt. Percent = number of complaints resolved within 21 days of receipt/number of complaints received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Log

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.16. Number and percent of providers that ensure waiver participants receive physical exams in accordance with ODP rules. Percent = number of providers that ensure waiver participants receive physical exams in accordance with ODP rules/number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Licensing Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measure a.i.1. Number and percent of critical incidents in which prompt action is taken to protect the participant's health, safety and rights. Both ODP and AEs review critical incidents within 24 hours of entrance into HCSIS. In any incident reviewed by ODP staff when it is not clear that adequate or prompt action has been taken to protect the participant's health, safety and rights, ODP will notify the AE that day (or the next business day if the incident was reviewed during non-work hours) to ensure that appropriate action relevant to the incident type has been taken. The AE will work with the provider to ensure that action has been undertaken to protect the participant's health, safety and rights and submit notification to ODP documenting what remediation actions occurred within 24 hours.

Performance Measure a.i.2. Number and percent of AEs that reviewed incidents within 24 hours.
Through the AEOMP, ODP evaluates incidents filed for participants in the sample to ensure timely review by the AE. ODP documents the timeframe within which remediation action has occurred or will be completed by the AE. ODP requires the AE to develop a Corrective Action Plan to prevent future occurrences.

Performance Measure a.i.3. Number and percent of critical incidents finalized within the required time frame.
ODP staff monitors a monthly report of critical incidents that are not finalized within 30 days and have no extension filed. This information is provided to AEs who contact providers to determine why incidents have not been finalized and why extensions have not been filed. If a provider does not finalize a critical incident within the required timeframe, the provider must finalize the incident within 5 days or file an extension request.

Performance Measure a.i.4. Number and percent of AEs that completed investigations in accordance with ODP standards. Through the AEOMP, ODP reviews a sample of investigations completed by AEs to determine if ODP investigation standards were met. If ODP expectations were not met, the AE will initiate remediation which may include counseling and/or retraining of certified investigators. Documentation of remediation actions must be submitted to ODP within 30 days.

Performance Measure a.i.5. Number and percent of critical incidents, confirmed, by type. This performance measure is designed to support evaluation of trends and patterns in the occurrence of critical incidents. The number and percent of critical incidents, confirmed, by type is reviewed to identify opportunities for systemic improvement as described in Appendix H.

Performance Measure a.i.6. Number and percent of critical incidents, confirmed, where corrective actions were carried out or planned by the appropriate entity within the required time frame. The AE and ODP sequentially review confirmed critical incidents to ensure that corrective actions resulting from certified investigation are carried out or planned by the appropriate entity within the required timeframe. If corrective actions are not carried out or planned by the appropriate entity within the required time frame, the AE or ODP will follow up to ensure the corrective actions are carried out or planned within 10 days. All remediation steps are entered into the incident report and are subject to final approval by ODP.

Performance Measure a.i.7. Number and percent of waiver participants who received information about reporting abuse, neglect, and exploitation. Through the AEOMP, ODP reviews a sample of records to determine if participants/families have been provided information about reporting abuse, neglect and exploitation. If there was no documentation that the information was provided, the AE will work with the SCO to provide the information to the participant/family and complete the required documentation on the ISP Signature Page. In some cases where the information was provided but not documented, the ISP Signature Page is updated. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days.

Performance Measure a.i.8. Number and percent of AEs that maintain documentation of incident management training. Through the AEOMP, ODP reviews AEs to determine if incident management training has occurred. When documentation of Incident Management training cannot be produced, the AE must complete the training and/or provide documentation that training has occurred and implement a Corrective Action Plan to prevent future noncompliance. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days.

Performance Measure a.i.9. Number and percent of waiver participants for whom there was an unreported critical incident, noted in the primary record and/or the service notes, by type. Through the AEOMP, ODP reviews a sample of participant records to ensure that critical incidents are reported. If it is determined that a critical incident was not reported, ODP will notify the AE immediately. The AE will instruct the provider to enter the information into HCSIS, work with the provider to ensure that action has been undertaken to protect the participant's health, safety and rights and will submit notification to ODP documenting what remediation actions occurred within 24 hours.

Performance Measure a.i.10. Number and percent of deaths, by cause of death. This performance measure is designed to support evaluation of trends and patterns in the occurrence of deaths. The number and percent of deaths is reviewed to identify opportunities for systemic improvement as described in Appendix H.

Remediation for Performance Measures a.i.11 through a.i.16 are continued in the Main Module Section B entitled Additional Needed Information (Optional)

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☐ **Annually**

Specify:	
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Every 6 months

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

ODP has developed Quality Oversight Groups in each of its four Regional Offices to review region-specific aggregate performance data in each of the six waiver assurance areas and a Community Services Quality Oversight Group to review statewide aggregate performance data in each of the six waiver assurance areas. ODP Regional Office Staff are assigned to participate in the compilation and analyses of aggregate data pertaining to their region, then join with ODP Central Office staff to compile and analyze data statewide. Regional analysis, conclusions, and recommendations are considered when statewide analysis is performed; conclusions and recommendations proposing system-wide improvements are made by the Community Services Quality Oversight Group.

Improvement activities recommended by the Community Services Quality Oversight Group and presented to ODP's Quality Leadership Board for final approval are identified in consideration of ODP's mission, vision and values. Health and safety of individuals is given highest priority. ODP assigns staff to implement quality improvements based on the scope of the design change and the expertise required. ODP involves additional stakeholders including Administrative Entities, providers, individuals served and their families, and other State agencies in consideration of the design change involved and specific input needed.

Examples of performance data that are reviewed and analyzed for opportunities to design and implement system improvements include aggregate discovery and remediation data demonstrating compliance with waiver assurances, risk management data, including total numbers of critical incidents, by type, total numbers of restraints, medication errors and deaths by cause, and financial management information including service and payment claims data.

Information used for trending and prioritizing opportunities for system improvements is also obtained through Independent Monitoring for Quality (IM4Q), a statewide method that the State has adopted to independently review quality of life issues for people in the ID system that includes a sample of waiver participants. IM4Q monitors satisfaction and outcomes of participants receiving services through indicators organized into areas of satisfaction, dignity and respect, choice and control, inclusion, and physical setting. Interview results are entered into HCSIS and when necessary used to make service changes. IM4Q data is aggregated into provider, AE, regional and statewide reports. Aggregate data is used for continuous quality improvement purposes by ODP, AE and provider quality groups. The State is working to enhance IM4Q so that it continues to evolve as an effective tool for capturing waiver participants' input and feedback.

As part of its QMS, ODP uses information from the AEOM process and other monitoring and oversight activities described above and in Appendix A-6 to identify areas needing clarification or improvement and, as

necessary, provide information and technical assistance. Administrative Entities, providers, and Supports Coordination Organizations are expected to collaborate with ODP in the implementation, monitoring and evaluation of changes designed to achieve system improvements.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

ODP uses a Plan-Do-Check-Act (PDCA) Model of continuous quality improvement. The steps in this model involve planning and implementing system design changes followed by monitoring of data results to check the effectiveness of the selected strategies. Using the analysis of performance data collected to identify next steps, the cycle is repeated. Depending on the area of focus, specific units within ODP are assigned responsibility for designing, initiating, monitoring and analyzing the effectiveness of system design changes and providing periodic, routine reports on progress to the Community Services Quality Oversight Group.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

On an annual basis, considering input from stakeholders and Quality Oversight Groups, ODP's Quality Leadership Board will assess program and operational performance as well as ODP's Quality Management Strategy. Results of this review may demonstrate a need to revise ODP's QMS, including changing priorities,using different approaches to ensure progress, modifying roles and responsibilities of key entities, and
modifying data sources in order to retrieve the information needed for measurement.

Appendix I: Financial Accountability

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 method employed to assure the integrity of payments made for waiver services is to conduct an annual fiscal year audit of state government, AEs, and for profit and nonprofit organizations in compliance with the requirements of the Single Audit Act of 1984, P.L. 98-502, and the Single Audit Act Amendments of 1996, P.L. 104-156 as well as Title 45, CFR 92. As outlined in the waiver cost report instructions, all subrecipients receiving $500,000 or more in combined State/Federal Funding (for profit and non-profit) need to have an annual audit conducted in accordance with Generally Accepted Governmental Auditing Standards (GAGAS). If the subrecipient is a nonprofit entity expending $500,000 or more in Federal Department of Health and Human Service Funding, a Single Audit is required. If the subrecipient is a

for-profit entity expending $500,000 or more in federal Department of Health and Human Services funding, the entity has the option to either have an annual audit in accordance with the Office of Management and Budget (OMB) Circular No. A-133 or a program specific audit conducted in accordance with GAGAS.

The Department of the Auditor General, an independent office, conducts the annual state fiscal year, Commonwealth of Pennsylvania Single Audit. OMB Circular No. A-133 issued pursuant to the Single Audit Act as amended, sets forth standards for obtaining consistency and uniformity for the audit of States, local governments, and non-profit organizations expending Federal awards. Providers are audited exclusively by contracting with CPA firms. Providers may also be selected for a GAGAS performance audit by the DepartmentÃ's Bureau of Financial Operations.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.1. Number and percent of claims paid using correct reimbursement rates. Percent = number of claims paid using correct reimbursement rates/number of claims paid.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:
PROMISe

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.2. Number and percent of claims paid for participants who were eligible on the date the service was provided. Percent = number of claims paid for participants who were eligible on the date the service was provided/number of claims paid.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PROMISe

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.3. Number and percent of claims paid where services were consistent with those in service plans. Percent = number of claims paid where services were consistent

with those in service plans/number of claims paid.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PROMISe

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
a.i.4. Number and percent of providers whose claims are supported by documentation that services were delivered. Percent = number of providers whose claims were supported by documentation that services were delivered/number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

For Performance Measure a.i.4., on a two-year cycle, 100% of waiver providers will undergo an onsite review by the appropriate AE(s) using a standardized provider monitoring tool developed by ODP. This tool examines program standards, requirements and compliance with waiver assurances. The AE (or AEs, if the provider renders service in multiple counties), will review a maximum of 10 participants from a random sample. If the provider is in multiple counties, the participants sampled will be 10.

For each participant in the sample, the AE will review progress notes, remittance advices and billing documentation for a two-week period in the prior quarter to determine if paid claims are supported by documentation that services were delivered.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measures a.i.1, a.i.2, and a.i.3. Number and percent of claims paid using correct reimbursement rates, number and percent of claims paid for participants who were eligible on the date the service was provided, and number and percent of claims paid where services were consistent with those in service plans.

The reimbursement logic built into PennsylvaniaÂ's Medicaid Management Information System (MMIS) ensures that providers are not paid more than the rate that is stored in the system, that waiver participants were eligible for services on the date the service was provided, and that services paid are authorized in the waiver participantÂ's approved ISP. A problem may be identified by a provider or providers, contractors, AE, ODP staff, or OMAP. The ODP Claims Resolution Section conducts research to identify if (a) the reimbursement rate was incorrect; (b) the eligibility information was incorrect, or (c) services paid are inconsistent with the services authorized in the ISP. If a problem is validated, appropriate corrective action is identified promptly. Systemic errors are corrected in collaboration with the MMIS contractor and, if necessary, with the contractor

who supports HCSIS. Rates or eligibility information entered into the system incorrectly are corrected and the universe of paid claims that was processed using the incorrect information is identified. In the rare event that an overpayment is made, ODP will immediately notify the provider and credit any overpayment on the next PROMISe billing cycle. Thus the FMAP amount charged via the MMIS system to CMS is rapidly corrected, generally within one month or less after an overpayment is discovered. If an underpayment is made, the provider is contacted to void and resubmit in order to obtain the increased rate.

Performance Measure a.i.4. Number and percent of providers whose claims are supported by documentation that services are delivered. Through the Provider Monitoring Process, AEs will review a random sample of participant records to determine if paid claims are supported by documentation that services were delivered. If during the review process a discrepancy is found (e.g. documentation does not match units billed), the provider will be requested by the AE to submit a corrective action plan that will specify the remediation action taken. Remediation is expected to occur within 30 days.

If 25% or more of the paid claims for a provider are not supported by documentation that services were delivered, the review sample will be expanded. Depending on the nature of the issue, additional records will be selected for review by the AE and ODP and the Department may initiate an expanded review or audit. Remediation may include locating documentation to support that services rendered are consistent with claim submission, training, voiding (and/or recovering) payments, and the initiation of provider sanctions, if the situation warrants. Department sanctions may range from restricting the provider from serving additional waiver participants to the termination of the agencyÂ's waiver program participation. Department staff will ensure that payments are adjusted where necessary and determine if the extent of the problem warrants further action.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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).

There are several approaches to set rates under the PPS, depending on the type of service: fee schedule rates, cost-based rates, outcome-based payment for goods and services, and participant-directed service rates. For purposes of this waiver program, outcomes-based refers to payment for the completion of a task or delivery of an item.

1. Medical Assistance (MA) Fee Schedule: Select services for placement on the fee schedule are identified by ODP prior to July 1 of each year.

MA Fee Schedule rates are developed using a market-based approach. This process includes a review of the service definitions and a determination of allowable cost components which reflect costs that are reasonable, necessary and related to the delivery of the service, as defined in DPW standards and Federal Cost Principles for Non-Profit Organizations (OMB Circular No. A-122, revised 5/10/2004). The fee schedule rates represent the maximum rates that DPW will pay for each service. In developing rates for each of the MA fee schedule services, the following occurs:

* ODP evaluates various independent data sources such as a Pennsylvania-specific compensation study and data from prior approved cost reports, as applicable, and considers the expected expenses for the delivery of the services under the waivers for the major allowable cost categories listed below:
-Wages for staff

-Employee-related expenses

-Productivity

-Program Indirect expenses

-Administration-related expenses

* One MA fee schedule rate is developed for each service and is adjusted by geographical area factors to reflect consideration for differences in wages observed across the Commonwealth.

* The fee schedule rates are established by the Department to fund the fee schedule services at a level sufficient to ensure access, encourage provider participation and promote provider choice, while at the same time ensuring cost effectiveness and fiscal accountability.

* Rates for the following services or components of a service are on the Medical Assistance fee schedule effective July 1, 2012: Behavioral Support, Physical Therapy, Occupational Therapy, Behavior Therapy, Speech/Language Therapy, Visual/Mobility Therapy, Nursing, Companion, Supports Broker and Residential enhanced staffing (Supplemental Habilitation and Additional Individualized Staffing), Unlicensed Home and Community Habilitation, licensed Day Habilitation Services (Older Adult, Adult training facilities), prevocational services, supported employment, respite (excluding respite camp), transitional work, Homemaker/Chore, and Supports Coordination.

* Each year additional services are considered for the fee schedule. The Waiver will be amended prospectively when additional services are added to the fee schedule contingent upon approval from CMS.

* Changes to the fee schedule rates and addition of services to the fee schedule are communicated through a public notice published in the Pennsylvania Bulletin prior to the effective date of any change or addition. Fee schedule rates are implemented prospectively.

2. Cost-Based: The cost-based rates are developed in accordance with Department standards and as follows:
* Cost and utilization data is collected using a standardized cost report as prepared and submitted by providers of service. Cost reports undergo a desk review in which the reported data is analyzed by ODP or its designee for completeness and accuracy based on cost report instructions and standardized review procedures.

* Cost report data is adjusted to reflect changes in the service definitions, if necessary, to account for differences in service definitions between the historical reporting period and the period in which the rates will be in effect.

* Providers who do not submit a cost report, do not successfully submit a cost report that is approved by ODP, or fail to submit an audit are assigned rates by ODP. New providers or current providers who offer new services (defined as providers that enroll and qualify to provide a new service after the cost report process is complete for that period and have no cost history) will also be assigned a rate by ODP. ODP assigns rates in the following manner:
o A provider shall be assigned the average of the provider's cost-based rates for an existing service at a new service location if the provider has an approved cost-based rate at another service location. A provider shall be assigned the area adjusted average of provider cost-based rates for new HCBS if:
(1) The cost report of the provider did not contain the new HCBS because the HCBS was not delivered during the reporting period.
(2) A provider is a new provider who was not delivering HCBS during the reporting period of the cost report.
o A provider shall be assigned the lowest rate calculated Statewide based on all provider cost reports for HCBS if a provider was required to submit a cost report and failed to submit a cost report.
o A provider who is required to submit an audit who then fails to submit an audit shall receive the lowest rate calculated Statewide.
o A provider who submits an audit which indicates the information in the cost report requires adjustment and the provider does not submit a revised cost report, the provider shall be assigned the lowest rate calculated Statewide.
o A provider that chooses to not submit a cost report or the cost report the provider submitted is not approved will be assigned the lowest rate calculated Statewide for each cost-based services the provider provides.

* For providers whose cost reports are approved, the cost report data undergo a review conducted by ODP. The review includes identifying outliers using a standardized set of criteria for all services with sufficient data points. For outliers, ODP conducts analysis to determine whether adjustments are needed to address variation among providers' unit costs.

* After the unit costs for each Residential Habilitation eligible service is adjusted through the outlier review process, a single, standardized vacancy factor is applied to reflect payment to providers for an average number of vacant days. The vacancy factor is applied to finalize a provider's residential rate. As such, a separate payment is not made to providers for the vacancy factor.

* Since the cost report data is from a historical time period, a Cost of Living Adjustment (COLA) is applied as appropriated by the General Assembly.

* A rate adjustment may be applied during the rate development/assignment process. This is called a Rate Adjustment Factor (RAF). A RAF is done prospectively and is based on an analysis of aggregate provider expenditures compared to the budget appropriation amount.

* Prior to the effective date of the rates, the methodology for calculating rates, including a description of the outlier review and rate assignment processes are communicated to the provider in the provider rate notice and in a public notice published in the Pennsylvania Bulletin. Cost report rates are implemented prospectively.

* The individual provider rate notice includes information on the process to contact ODP on questions and concerns related to the provider rate notice. Providers have the right to appeal as outlined in 55 Pa. Code Chapter 41. The appeal language is included in the individual provider rate notice.

* Providers meeting the criteria for audit submission outlined in I-2 are required to submit their Audited Financial Statements to ODP for review. ODP may require resubmission of the cost report if there are material differences between the independent audit and the approved cost report filed by the provider. ODP may also conduct additional audits of providers' costs reports. ODP may recalculate rates for providers who have material differences between their approved and resubmitted cost reports.

* ODP has a process in place to allow for additional staffing costs above what is included in the approved cost report rate for current staffing if there is a new participant entering the program that has above average staffing needs.

* Ã‚Â•Effective July 1, 2012, rates for the following services or components of a service are developed using the cost-based methodology: Unlicensed Residential Habilitation in Community Homes, Unlicensed Residential Habilitation in Family Living Homes, Child Residential Services, Community Residential Rehabilitation Services, Adult Family Living Home, Child Family Living Home, Licensed Residential Habilitation in Community Homes, and Transportation (per trip). Transportation providers are both private and local government agency providers.

3. Outcome-based payment for vendor goods and services:

* ODP reimburses outcome-based services based on the cost charged to the general public for the good or service. Services reimbursed under the outcome-based approach are: Home and Vehicle Accessibility Adaptations, Assistive Technology, Specialized Supplies, Education Support, Public Transportation and Respite Camp.

*Outcome-based services must be obtained at the lowest practicable cost using a system of competitive bidding or written estimates or the market price of comparable goods or services available in the provider's region.

* Transportation Mileage is reimbursed at the established rate for DPW employees for business travel.

4. Participant-directed service rates: Rates for participant-directed services are established through the development of standard wage ranges (which apply to both Vendor Fiscal/Employer Agent and Agency with Choice models) and a fee schedule (Agency with Choice model).

* ODP establishes the Vendor Fiscal/Employer Agent wage ranges by evaluating various data sources, such as a Pennsylvania-specific compensation study.

* ODP establishes wage ranges and fee schedule for Agency with Choice rates. The AWC fee schedule rate development follows the same process as that outlined previously in this section for non-participant directed fee schedule services.

* Effective July 1, 2012, rates for the following services or components of a service are developed consistent with the participant-directed methodologies described above: Homemaker/Chore, Supports Broker, Companion Services, Supported Employment, Unlicensed Home & Community Habilitation, and Unlicensed Respite. If the participant chooses to self-direct some or all of these needed services, he or she will utilize the current Vendor Fiscal/Employer Agent or Agency With Choice wage range communication issue by ODP. If the participant chooses not to self-direct any of these services, the MA Fee Schedule rate will be utilized.

The Vendor Fiscal/Employer Agent and Agency with Choice wage ranges are issued by ODP prior to July 1 each year in a standard ODP communication. In addition, the Agency with Choice Medical Assistance fee schedule rates are communicated prior to July 1 each year through a public notice published in the Pennsylvania Bulletin. Wage ranges and fee schedule rates, when applicable, are implemented prospectively.

Claims are processed through PROMISe which is administered by the Office of Medical Assistance Programs (OMAP) and the Department'ÃƒÂƒÃ‚,ÂƒÃƒÂ‚Ã‚,Â‚ÃƒÂƒÃ‚,Â‚ÃƒÂƒÃ‚,Â‚'s Bureau of Information Systems (BIS). Claims and payments are monitored by ODP and AEs through the use of PROMISe and HCSIS generated reports.

In the future, ODP may use a variety of mechanisms to obtain public comment on rate determination methodologies, including, but not limited to stakeholder workgroup discussions, draft documents distributed for public comment, communications and public meetings.

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:

All waiver providers, including cost based and fee schedule providers, vendors, FMS providers and Organized Health Care Delivery System (OHCDS) providers that sign a provider agreement or contract with ODP bill through the PROMISe system and are paid by the state Treasury. Qualified support service workers and vendors providing services through an FMS for self directing participants and vendors paid by an OHCDS provider for non self-directing participants do not bill directly through the PROMISe system as this is the role and responsibility of the FMS and the OHCDS provider.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **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.**

***Select at least one*:**

☐ **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).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **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.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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:

Provider billings are verified through PROMISe. PROMISe includes edits to determine if the participant is eligible for Medicaid payment on the date of service and ensure that the service was part of the participant's plan. The service is approved for payment by PROMISe only if the service is authorized and there are sufficient units available on the participant's support plan. Validation that the service has been provided occurs through the audit process at the end of the year.

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: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

◉ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **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) and 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:

○ **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:

○ **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:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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*):

☑ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **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:

☐ **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.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **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.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

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:

Supports Coordination Organizations may receive payment for waiver funded supports coordination services. ODP makes payments based on rates established by the process outlined in Appendix I.2.a. Rate Determination Methods, at which time reasonable costs are taken into consideration. Further, ODP's fiscal regulations describe allowable costs and specifically state that the costs for services must "be reasonable for the performance of the HCBS" and "consistent with policies and procedures that apply uniformly to both Federally-funded and other activities of the organization" (55 Pa. Code, Chapter 51.81 (d)).

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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:*

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- (●) **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.**
- ( ) **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.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

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

- ( ) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

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:

Agencies that are qualified as a waiver provider, and render at least one direct waiver service may function as an Organized Health Care Delivery System (OHCDS). Providers that function as an OHCDS may subcontract with individuals or entities that have been designated as vendor services, if the vendor does not wish to enter into a direct relationship with ODP. Entities that function as an OHCDS for vendor services are responsible to ensure that subcontracted entities meet all applicable provider qualification standards for the service they are rendering. In the event of subcontracting arrangements, the OHCDS must comply with ODP's Subcontracting Arrangements policies.

OHCDS providers must meet the following criteria:
• Enroll in PROMISe as a provider of Consolidated Waiver services;

• Enter service offering(s) in HCSIS;

• Successfully complete the Provider Qualifications module in HCSIS for at least one waiver service and ensure the requirements of Appendix C, including provider qualification standards, are met;

• Enter into a Provider Agreement for Participation in Pennsylvania's Consolidated Waiver with ODP;

• Utilize the rate that is charged to the general public, dependent on the waiver service provided. See the last paragraph of this section for additional requirements related to payment for vendor services;

• Render at least one Medicaid service;

• Cooperate with provider monitoring conducted by ODP or one of its designees, and ensure the subcontracted vendor cooperates with such monitoring when needed or requested;

• Cooperate with other monitoring activities, such as Supports Coordination monitoring, and ensure the vendor cooperates with such monitoring; and

• Maintain documentation on service delivery.

Participants are provided with information on willing and qualified providers, as outlined in Appendix D-1-f. This information includes the providers identified in the ODP Services and Support Directory (SSD) for services needed by the participant. The SSD includes both providers that function as an OHCDS and those that do not. The participant is free to choose among the willing and qualified providers, despite their designation as an OHCDS. The SSD does not differentiate between providers functioning as an OHCDS and those that do not.

AEs are required to complete provider monitoring of all Waiver providers in accordance with this Waiver and as per ODP policies and procedures. The monitoring is required to be conducted to ensure ongoing compliance with the providers outlined in the current ODP/Provider Agreement, applicable licensing requirements, and written policies and procedures. The monitoring must include a review of compliance with applicable provider qualification standards for all services for which the provider is enrolled and qualified to render.

The AE Operating Agreement requires AEs, as part of provider monitoring, to review OHCDS contracts with vendors to ensure they meet applicable state and federal requirements.

The cost of the vendor good or service must be the same cost charged to the general (or self-paying) public. The cost of the good must be verified by the AE. Prior to authorizing the service, the AE will verify that the cost of the vendor rate for goods or services does not exceed the rate charged to the general public.

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

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **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.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

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*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

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:

☐ **Other State Level Source(s) of Funds.**

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:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

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*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

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:

☐ **Other Local Government Level Source(s) of Funds.**

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

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

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**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

◉ **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:

ODP utilizes a standardized cost-based methodology in determining rates for residential waiver services. Providers are required to use a standardized cost report and follow instructions outlined by ODP. The cost report specifically instructs providers to report waiver eligible and ineligible costs separately for residential services. Providers are required to ensure that room and board costs are not entered as part of eligible costs on the cost report. ODP uses eligible costs only from the cost report to develop the waiver eligible residential rates.

Providers complete and submit cost reports for the services they provide. The AE is responsible to ensure that cost reports have been completed in accordance with ODPÂ's cost report instructions.

When Respite is provided in an unlicensed residential setting room and board is excluded from the Medicaid payment to the provider.

Appendix I: Financial Accountability

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:*

- (●) **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.**
- ( ) **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.**

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:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
  - i. **Co-Pay Arrangement.**

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

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

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

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

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*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **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:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the

Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	91694.39	6450.72	98145.11	148768.11	6220.96	154989.07	56843.96
2	98068.67	6516.89	104585.56	151743.48	6345.38	158088.86	53503.30
3	104776.17	6624.90	111401.07	154778.35	6472.28	161250.63	49849.56
4	104801.80	6714.17	111515.97	157873.91	6601.73	164475.64	52959.67
5	104827.10	6804.92	111632.02	161031.39	6733.76	167765.15	56133.13

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	17637	17637
Year 2	17807	17807
Year 3	17867	17867
Year 4	17982	17982
Year 5	18097	18097

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The Office of Developmental Programs (ODP) based the average length of stay (ALOS) on historical enrollment information, utilization and user counts for the Waiver. Based upon recent trends ODP found that the ALOS does not vary significantly from year to year, even with the change in participants with newly enrolled individuals. Therefore, the estimated ALOS of 342 days is consistent with historical experience and not expected to change in the projection years.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for

these estimates is as follows:

Factor D is based on average FY'12-13 rates and adjusted FY'11-12 historical user counts and units utilization, calculated from actual Waiver paid claims data through December 31, 2012. The Year 1 and Year 2 component costs and utilization per user numbers are based on estimates provided in DPW's FY'12-13 budget update as of February 2013, utilizing five months of actual FY'12-13 data. To project the expenditures in Years 3 through 5, ODP then assumed the user counts would increase according to the capacity schedule submitted in the Waiver renewal while the average rates and average utilization per user would remain the same as in Year 2. Though historical experience would suggest rising rates and utilization per user, ODP anticipates that efforts to continue enhancing the plan development, potential service definition changes and authorization practices across the Commonwealth will have a stabilizing impact on overall expenditures.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' on the waiver renewal was based on the average per participant non-waiver state plan service costs for SFY 2009-2010, as reported in the CMS-372 reports. Subsequent to the approval of the waiver renewal, ODP received legislative funding for bringing PA residents off the waiting list. ODP received two years of new initiatives. Funding for an additional 430 new participants was provided in year one (FY 2012-2013) and funding for 380 new participants for year two (FY 2013-2014) for the consolidated waiver. In addition to the waiting list funding, ODP continues to see more complex acuity (primarily with new participants) which is driving up the need for services. This is particularly true for participants with complex behavioral needs. This is reflected in the cost estimates in residential habilitation. Finally, more participants entering the waiver are requiring residential eligible care than the legacy participants they replace. This, combined with increased acuity described above, drives cost estimates in the consolidated waiver – primarily residential habilitation. ODP did not adjust Year one costs and/or participants for the most current waiver amendment as ODP is now in year two of the waiver renewal. These considerations are reflected in the Schedule J estimates that were revised for Year two on the current amendment.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on the SFY 2010-2011 ICF/ID expenditures and users and the total operating costs and users for the state centers. ODP assumed the average cost per user increased by 2% annually fom SFY 2010-2011 to SFY 2012-2013 and would continue to increase by approximately 2% annually for the term of this waiver based on consistent with the historical growth for these services.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' on the waiver renewal was based on the SFY 2009-2010 average cost per recipient for non-institutional state plan services provided to individuals in the ICF/ID program and state centers, as reported in the CMS-372 reports, as reported in the CMS-372 reports. Subsequent to the approval of the waiver renewal, ODP received legislative funding for bringing PA residents off the waiting list. ODP received two years of new initiatives. Funding for an additional 430 new participants was provided in year one (FY 2012-2013) and funding for 380 new participants for year two (FY 2013-2014) for the consolidated waiver. In addition to the waiting list funding, ODP continues to see more complex acuity (primarily with new participants) which is driving up the need for services. This is particularly true for participants with complex behavioral needs. This is reflected in the cost estimates in residential habilitation. Finally, more participants entering the waiver are requiring residential eligible care than the legacy participants they replace. This, combined with increased acuity described above, drives cost estimates in the consolidated waiver – primarily residential habilitation. ODP did not adjust Year one costs and/or participants for the most current waiver amendment as ODP is now in year two of the waiver renewal. These considerations are reflected in the Schedule J estimates that were revised for Year two on the current amendment.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Education Support Services Total:						**63597.60**
Education Support Services	Outcome Based Unit	10	2.19	2904.00	**63597.60**	
Home and Community Habilitation (Unlicensed) Total:						**114954511.96**
Base	15 minutes	306	2013.76	2.34	**1441932.71**	
Level 1	15 minutes	259	2405.61	3.44	**2143302.29**	
Level 2	15 minutes	274	2515.21	4.32	**2977203.77**	
Level 3	15 minutes	4139	3335.56	7.65	**105615003.73**	
Level 4	15 minutes	71	2346.35	16.67	**2777069.47**	
Homemaker/Chore Total:						**120776.58**

Homemaker/Chore	Hour	57	156.03	13.58	**120776.58**	
Licensed Day Habilitation Total:						**120076448.70**
Base	15 minutes	3120	4321.19	2.55	**34379387.64**	
Level 1	15 minutes	1729	3972.34	3.32	**22802343.86**	
Level 2	15 minutes	1882	4171.37	4.24	**33286197.76**	
Level 3	15 minutes	960	3105.58	9.76	**29098042.37**	
Level 4	15 minutes	26	1323.92	14.83	**510477.07**	
Prevocational Services Total:						**51494463.08**
Base	15 minutes	2729	4261.21	1.94	**22559953.65**	
Level 1	15 minutes	1284	4306.00	2.31	**12771768.24**	
Level 2	15 minutes	744	4201.09	3.06	**9564369.54**	
Level 3	15 minutes	252	3087.02	8.35	**6495707.48**	
Level 4	15 minutes	2	3288.41	15.61	**102664.16**	
Residential Habilitation Total:						**1189885096.58**
15 minute	15 minutes	719	8280.82	4.72	**28102453.22**	
24 Hour	24 hours	13152	325.06	271.75	**1161782643.36**	
Respite Total:						**6543315.26**
Base - 15 min	15 minutes	230	209.77	2.59	**124959.99**	
Level 1 - 15 min	15 minutes	127	189.48	2.72	**65453.97**	
Level 2 - 15 min	15 minutes	215	624.57	5.94	**797638.35**	
Level 3 - 15 min	15 minutes	7	132.31	9.62	**8909.76**	
Base - 24 hr	24 hours	1176	13.90	116.50	**1904355.60**	
Level 1 - 24 hr	24 hours	141	30.00	146.08	**617918.40**	
Level 2 - 24	24 hours	738	13.00	311.36	**2987187.84**	
Level 3 - 24	24 hours	12	6.00	512.38	**36891.36**	
Supported Employment - Job Finding and Job Support Total:						**7669237.76**
Supported Employment - Job Finding and Job Support	15 minutes	1069	733.56	9.78	**7669237.76**	
Supports Coordination Total:						**48912603.91**
Supports Coordination	15 minutes	17637	140.42	19.75	**48912603.92**	
Nursing Total:						**41261727.10**
Nursing	15 minutes				**41261727.10**	

		391	8388.61	12.58		
Therapy Services Total:						**165268.25**
Therapy Services	15 minutes	230	38.14	18.84	**165268.25**	
Supports Broker Services Total:						**21326.66**
Supports Broker Services	15 minutes	8	467.69	5.70	**21326.66**	
Assistive Technology Total:						**184020.52**
Assistive Technology	Outcome Based Unit	78	3.75	629.13	**184020.52**	
Behavioral Support Total:						**9562745.70**
Behavioral Support	15 minutes	3845	138.17	18.00	**9562745.70**	
Companion Total:						**9403619.60**
Base	15 minutes	0	0.00	1.09	**0.00**	
Level 1	15 minutes	0	0.00	1.26	**0.00**	
Level 2	15 minutes	27	2204.72	2.06	**122626.53**	
Level 3	15 minutes	685	3430.10	3.95	**9280993.08**	
Home Accessibility Adaptations Total:						**1220371.91**
Home Accessibility Adaptations	Outcome Based Unit	166	2.10	3500.78	**1220371.91**	
Specialized Supplies Total:						**17488.39**
Specialized Supplies	Outcome Based Unit	52	5.98	56.24	**17488.39**	
Transitional Work Services Total:						**5919628.73**
Base	15 minutes	313	3203.96	2.51	**2517127.09**	
Level 1	15 minutes	150	2125.17	3.35	**1067897.92**	
Level 2	15 minutes	183	1590.51	4.23	**1231197.89**	
Level 3	15 minutes	63	1641.46	10.67	**1103405.83**	
Transportation Total:						**9452080.63**
Transportation (Mile)	Mile	457	3088.53	0.56	**790416.60**	
Transportation (Trip)	Per Trip	748	333.85	25.77	**6435279.25**	
Per Purchase - Public Transportation	Outcome Based Unit	820	157.58	17.23	**2226384.79**	
Vehicle Accessibility Adaptations Total:						**285670.00**
Vehicle Accessibility Adaptations	Outcome Based Unit	40	1.75	4081.00	**285670.00**	

GRAND TOTAL:	**1617213998.93**
Total Estimated Unduplicated Participants:	**17637**
Factor D (Divide total by number of participants):	**91694.39**
Average Length of Stay on the Waiver:	342

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Education Support Services Total:						**73790.64**
Education Support Services	Outcome Based Unit	11	2.31	2904.00	**73790.64**	
Home and Community Habilitation (Unlicensed) Total:						**128335663.79**
Base	15 minutes	311	2132.61	2.34	**1551985.60**	
Level 1	15 minutes	266	2547.59	3.44	**2331146.75**	
Level 2	15 minutes	289	2663.66	4.32	**3325526.24**	
Level 3	15 minutes	4372	3532.42	7.65	**118144612.84**	
Level 4	15 minutes	72	2484.83	16.67	**2982392.36**	
Homemaker/Chore Total:						**150345.27**
Homemaker/Chore	Hour	67	165.24	13.58	**150345.27**	
Licensed Day Habilitation Total:						**129576244.93**
Base	15 minutes	3191	4576.22	2.55	**37236930.95**	
Level 1	15 minutes	1762	4206.78	3.32	**24608989.92**	
Level 2	15 minutes	1918	4417.55	4.24	**35924930.22**	
Level 3	15 minutes	974	3288.87	9.76	**31264787.55**	
Level 4	15 minutes	26	1402.06	14.83	**540606.29**	
Prevocational Services Total:						**56061398.77**
Base	15 minutes	2820	4512.70	1.94	**24688079.16**	
Level 1	15 minutes	1312	4560.13	2.31	**13820477.19**	
Level 2	15 minutes	760	4449.03	3.06	**10346664.17**	
Level 3	15 minutes	260	3269.21	8.35	**7097454.91**	
Level 4	15 minutes	2	3482.49	15.61	**108723.34**	
Residential Habilitation Total:						**1278764419.65**
15 minute					**30340503.71**	

	15 minutes	733	8769.54	4.72		
24 Hour	24 hours	13345	344.25	271.75	**1248423915.94**	
Respite Total:						**7421997.12**
Base - 15 min	15 minutes	233	222.15	2.59	**134060.86**	
Level 1 - 15 min	15 minutes	131	200.66	2.72	**71499.17**	
Level 2 - 15 min	15 minutes	263	661.43	5.94	**1033299.17**	
Level 3 - 15 min	15 minutes	7	140.11	9.62	**9435.01**	
Base - 24 hr	24 hour	1195	14.72	116.50	**2049281.60**	
Level 1 - 24 hr	24 hour	144	31.77	146.08	**668298.47**	
Level 2 - 24	24 hour	797	13.77	311.36	**3417079.48**	
Level 3 - 24	24 hours	12	6.35	512.38	**39043.36**	
Supported Employment - Job Finding and Job Support Total:						**8342157.11**
Supported Employment - Job Finding and Job Support	15 minutes	1098	776.85	9.78	**8342157.11**	
Supports Coordination Total:						**51796645.46**
Supports Coordination	15 minutes	17807	147.28	19.75	**51796645.46**	
Nursing Total:						**45149755.36**
Nursing	15 minutes	404	8883.69	12.58	**45149755.36**	
Therapy Services Total:						**175778.90**
Therapy Services	15 minutes	231	40.39	18.84	**175778.90**	
Supports Broker Services Total:						**22585.22**
Supports Broker Services	15 minutes	8	495.29	5.70	**22585.22**	
Assistive Technology Total:						**175445.48**
Assistive Technology	Outcome Based Unit	79	3.53	629.13	**175445.48**	
Behavioral Support Total:						**10311170.40**
Behavioral Support	15 minutes	3915	146.32	18.00	**10311170.40**	
Companion Total:						**11183124.76**
Base	15 minutes	0	0.00	1.09	**0.00**	
Level 1	15 minutes	0	0.00	1.26	**0.00**	
Level 2	15 minutes	31	2334.84	2.06	**149102.88**	
Level 3	15 minutes	769	3632.54	3.95	**11034021.88**	
Home Accessibility						

Adaptations Total:						**1155362.42**
Home Accessibility Adaptations	Outcome Based Unit	171	1.93	3500.78	**1155362.42**	
Specialized Supplies Total:						**17824.71**
Specialized Supplies	Outcome Based Unit	53	5.98	56.24	**17824.71**	
Transitional Work Services Total:						**6380977.49**
Base	15 minutes	320	3393.05	2.51	**2725297.76**	
Level 1	15 minutes	156	2250.60	3.35	**1176163.56**	
Level 2	15 minutes	184	1684.38	4.23	**1310986.64**	
Level 3	15 minutes	63	1738.34	10.67	**1168529.53**	
Transportation Total:						**10928368.87**
Transportation (Mile)	Mile	482	3270.81	0.56	**882857.04**	
Transportation (Trip)	Trip	804	353.56	25.77	**7325437.92**	
Per Purchase - Public Transportation	Outcome Based Unit	946	166.88	17.23	**2720073.91**	
Vehicle Accessibility Adaptations Total:						**285670.00**
Vehicle Accessibility Adaptations	Outcome Based Unit	40	1.75	4081.00	**285670.00**	
				GRAND TOTAL:		**1746308726.34**
				Total Estimated Unduplicated Participants:		**17807**
				Factor D (Divide total by number of participants):		**98068.67**
				Average Length of Stay on the Waiver:		342

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Education Support Services Total:						**80498.88**
Education Support Services	Outcome Based Unit	12	2.31	2904.00	**80498.88**	
Home and Community Habilitation (Unlicensed) Total:						**148740172.02**
Base	15 minutes	313	2462.53	2.34	**1803606.22**	
Level 1	15 minutes	267	2941.70	3.44	**2701892.62**	

Level 2	15 minutes	290	3075.73	4.32	**3853274.54**	
Level 3	15 minutes	4387	4078.89	7.65	**136889791.79**	
Level 4	15 minutes	73	2869.24	16.67	**3491606.85**	
Homemaker/Chore Total:						**152589.23**
Homemaker/Chore	Hour	68	165.24	13.58	**152589.23**	
Licensed Day Habilitation Total:						**150190394.62**
Base	15 minutes	3202	5284.16	2.55	**43145694.82**	
Level 1	15 minutes	1768	4857.57	3.32	**28512770.08**	
Level 2	15 minutes	1925	5100.95	4.24	**41633953.90**	
Level 3	15 minutes	978	3797.66	9.76	**36249728.04**	
Level 4	15 minutes	27	1618.96	14.83	**648247.77**	
Prevocational Services Total:						**65037450.77**
Base	15 minutes	2830	5210.81	1.94	**28608389.06**	
Level 1	15 minuts	1317	5265.59	2.31	**16019346.49**	
Level 2	15 minutes	763	5137.29	3.06	**11994441.95**	
Level 3	15 minutes	261	3774.96	8.35	**8226959.08**	
Level 4	15 minutes	3	4021.23	15.61	**188314.20**	
Residential Habilitation Total:						**1332914642.31**
15 minute	15 minutes	736	10126.19	4.89	**36444562.86**	
24 Hour	24 hours	13390	344.25	281.26	**1296470079.45**	
Respite Total:						**7651833.42**
Base - 15 min	15 minutes	234	256.51	2.59	**155460.45**	
Level 1 - 15 min	15 minutes	132	231.70	2.72	**83189.57**	
Level 2 - 15 min	15 minutes	264	763.76	5.94	**1197697.88**	
Level 3 - 15 min	15 minutes	8	161.79	9.62	**12451.36**	
Base - 24 hr	24 hours	1200	14.72	116.50	**2057856.00**	
Level 1 - 24 hr	24 hours	145	31.77	146.08	**672939.43**	
Level 2 - 24	24 hours	800	13.77	311.36	**3429941.76**	
Level 3 - 24	24 hours	13	6.35	512.38	**42296.97**	
Supported Employment - Job Finding and Job Support Total:						**9667794.65**
Supported Employment - Job	15 minutes	1102	897.03	9.78	**9667794.65**	

Finding and Job Support						
Supports Coordination Total:						**60013153.63**
Supports Coordination	15 minutes	17867	170.07	19.75	**60013153.63**	
Nursing Total:						**52392529.84**
Nursing	15 minutes	406	10258.00	12.58	**52392529.84**	
Therapy Services Total:						**203857.84**
Therapy Services	15 minutes	232	46.64	18.84	**203857.84**	
Supports Broker Services Total:						**29338.98**
Supports Broker Services	15 minutes	9	571.91	5.70	**29338.98**	
Assistive Technology Total:						**177666.31**
Assistive Technology	Outcome Based Unit	80	3.53	629.13	**177666.31**	
Behavioral Support Total:						**11949189.12**
Behavioral Support	15 minutes	3929	168.96	18.00	**11949189.12**	
Companion Total:						**12968431.26**
Base	15 minutes	0	0.00	1.09	**0.00**	
Level 1	15 minutes	0	0.00	1.26	**0.00**	
Level 2	15 minutes	32	2696.04	2.06	**177722.96**	
Level 3	15 minutes	772	4194.50	3.95	**12790708.30**	
Home Accessibility Adaptations Total:						**1162118.93**
Home Accessibility Adaptations	Outcome Based Unit	172	1.93	3500.78	**1162118.93**	
Specialized Supplies Total:						**18161.02**
Specialized Supplies	Outcome Based Unit	54	5.98	56.24	**18161.02**	
Transitional Work Services Total:						**7426135.04**
Base	15 minutes	322	3917.96	2.51	**3166573.63**	
Level 1	15 minutes	157	2598.77	3.35	**1366823.08**	
Level 2	15 minutes	185	1944.95	4.23	**1522020.62**	
Level 3	15 minutes	64	2007.26	10.67	**1370717.71**	
Transportation Total:						**10970867.27**
Transportation (Mile)	Mile	484	3270.81	0.56	**886520.34**	
Transportation (Trip)	Trip	807	353.56	25.77	**7352771.65**	
Per Purchase - Public Transportation	Outcome Based Unit	950	166.88	17.23	**2731575.28**	
Vehicle Accessibility Adaptations Total:						**288918.59**

Vehicle Accessibility Adaptations	Outcome Based Unit	41	1.75	4026.74	288918.60	
				GRAND TOTAL:		1872035743.73
				Total Estimated Unduplicated Participants:		17867
				Factor D (Divide total by number of participants):		104776.17
				Average Length of Stay on the Waiver:		342

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Education Support Services Total:						**87207.12**
Education Support Services	Outcome Based Unit	13	2.31	2904.00	**87207.12**	
Home and Community Habilitation (Unlicensed) Total:						**149757004.16**
Base	15 minutes	316	2462.53	2.34	**1820893.18**	
Level 1	15 minutes	269	2941.70	3.44	**2722131.51**	
Level 2	15 minutes	292	3075.73	4.32	**3879848.85**	
Level 3	15 minutes	4416	4078.89	7.65	**137794693.54**	
Level 4	15 minutes	74	2869.24	16.67	**3539437.08**	
Homemaker/Chore Total:						**154833.18**
Homemaker/Chore	Hour	69	165.24	13.58	**154833.18**	
Licensed Day Habilitation Total:						**151231516.65**
Base	15 minutes	3223	5284.16	2.55	**43428661.58**	
Level 1	15 minutes	1780	4857.57	3.32	**28706295.67**	
Level 2	15 minutes	1938	5100.95	4.24	**41915118.26**	
Level 3	15 minutes	985	3797.66	9.76	**36509184.18**	
Level 4	15 minutes	28	1618.96	14.83	**672256.95**	
Prevocational Services Total:						**65543406.62**
Base	15 minutes	2849	5210.81	1.94	**28800459.52**	
Level 1	15 minutes	1326	5265.59	2.31	**16128818.11**	

Level 2	15 minutes	768	5137.29	3.06	**12073042.48**	
Level 3	15 minutes	263	3774.96	8.35	**8290000.91**	
Level 4	15 minutes	4	4021.23	15.61	**251085.60**	
Residential Habilitation Total:						**1341585894.34**
15 minute	15 minutes	741	10126.19	4.89	**36692148.20**	
24 Hour	24 hours	13477	344.25	281.26	**1304893746.14**	
Respite Total:						**7711760.43**
Base - 15 min	15 minutes	236	256.51	2.59	**156789.17**	
Level 1 - 15 min	15 minutes	133	231.70	2.72	**83819.79**	
Level 2 - 15 min	15 minutes	266	763.76	5.94	**1206771.35**	
Level 3 - 15 min	15 minutes	9	161.79	9.62	**14007.78**	
Base - 24 hr	24 hours	1208	14.72	116.50	**2071575.04**	
Level 1 - 24 hr	24 hours	146	31.77	146.08	**677580.39**	
Level 2 - 24	24 hours	806	13.77	311.36	**3455666.32**	
Level 3 - 24	24 hours	14	6.35	512.38	**45550.58**	
Supported Employment - Job Finding and Job Support Total:						**9737978.27**
Supported Employment - Job Finding and Job Support	15 minutes	1110	897.03	9.78	**9737978.27**	
Supports Coordination Total:						**60399425.12**
Supports Coordination	15 minutes	17982	170.07	19.75	**60399425.12**	
Nursing Total:						**52779666.76**
Nursing	15 minutes	409	10258.00	12.58	**52779666.76**	
Therapy Services Total:						**205615.24**
Therapy Services	15 minutes	234	46.64	18.84	**205615.24**	
Supports Broker Services Total:						**32598.87**
Supports Broker Services	15 minutes	10	571.91	5.70	**32598.87**	
Assistive Technology Total:						**179887.14**
Assistive Technology	Outcome Based Unit	81	3.53	629.13	**179887.14**	
Behavioral Support Total:						**12028262.40**
Behavioral Support	15 minutes	3955	168.96	18.00	**12028262.40**	
Companion Total:						**13056826.47**
Base	15 minutes				**0.00**	

		0	0.00	1.09		
Level 1	15 minutes	0	0.00	1.26	**0.00**	
Level 2	15 minutes	33	2696.04	2.06	**183276.80**	
Level 3	15 minutes	777	4194.50	3.95	**12873549.68**	
Home Accessibility Adaptations Total:						**1175631.94**
Home Accessibility Adaptations	Outcome Based Unit	174	1.93	3500.78	**1175631.94**	
Specialized Supplies Total:						**18497.34**
Specialized Supplies	Outcome Based Unit	55	5.98	56.24	**18497.34**	
Transitional Work Services Total:						**7510920.78**
Base	15 minutes	325	3917.96	2.51	**3196075.87**	
Level 1	15 minutes	159	2598.77	3.35	**1384234.84**	
Level 2	15 minutes	187	1944.95	4.23	**1538474.90**	
Level 3	15 minutes	65	2007.26	10.67	**1392135.17**	
Transportation Total:						**11052988.73**
Transportation (Mile)	Mile	488	3270.81	0.56	**893846.96**	
Transportation (Trip)	Trip	813	353.56	25.77	**7407439.10**	
Per Purchase - Public Transportation	Outcome Based Unit	957	166.88	17.23	**2751702.68**	
Vehicle Accessibility Adaptations Total:						**295965.39**
Vehicle Accessibility Adaptations	Outcome Based Unit	42	1.75	4026.74	**295965.39**	
GRAND TOTAL:						**1884545886.95**
Total Estimated Unduplicated Participants:						**17982**
Factor D (Divide total by number of participants):						**104801.80**
Average Length of Stay on the Waiver:						342

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Education Support Services Total:						**93915.36**
Education Support						

Services	Outcome Based Unit	14	2.31	2904.00	**93915.36**	
Home and Community Habilitation (Unlicensed) Total:						**150773836.30**
Base	15 minutes	319	2462.53	2.34	**1838180.14**	
Level 1	15 minutes	271	2941.70	3.44	**2742370.41**	
Level 2	15 minutes	294	3075.73	4.32	**3906423.16**	
Level 3	15 minutes	4445	4078.89	7.65	**138699595.28**	
Level 4	15 minutes	75	2869.24	16.67	**3587267.31**	
Homemaker/Chore Total:						**157077.14**
Homemaker/Chore	Hour	70	165.24	13.58	**157077.14**	
Licensed Day Habilitation Total:						**152272638.68**
Base	15 minutes	3244	5284.16	2.55	**43711628.35**	
Level 1	15 minutes	1792	4857.57	3.32	**28899821.26**	
Level 2	15 minutes	1951	5100.95	4.24	**42196282.63**	
Level 3	15 minutes	992	3797.66	9.76	**36768640.31**	
Level 4	15 minutes	29	1618.96	14.83	**696266.13**	
Prevocational Services Total:						**66049362.46**
Base	15 minutes	2868	5210.81	1.94	**28992529.98**	
Level 1	15 minutes	1335	5265.59	2.31	**16238289.72**	
Level 2	15 minutes	773	5137.29	3.06	**12151643.02**	
Level 3	15 minutes	265	3774.96	8.35	**8353042.74**	
Level 4	15 minutes	5	4021.23	15.61	**313857.00**	
Residential Habilitation Total:						**1350257146.37**
15 minute	15 minutes	746	10126.19	4.89	**36939733.55**	
24 Hour	24 hour	13564	344.25	281.26	**1313317412.82**	
Respite Total:						**7771687.44**
Base - 15 min	15 minutes	238	256.51	2.59	**158117.89**	
Level 1 - 15 min	15 minutes	134	231.70	2.72	**84450.02**	
Level 2 - 15 min	15 minutes	268	763.76	5.94	**1215844.82**	
Level 3 - 15 min	15 minutes	10	161.79	9.62	**15564.20**	
Base - 24 hr	24 hours	1216	14.72	116.50	**2085294.08**	
Level 1 - 24 hr	24 hours	147	31.77	146.08	**682221.36**	

Level 2 - 24	24 hours	812	13.77	311.36	**3481390.89**	
Level 3 - 24	24 hours	15	6.35	512.38	**48804.20**	
Supported Employment - Job Finding and Job Support Total:						**9808161.90**
Supported Employment - Job Finding and Job Support	15 minutes	1118	897.03	9.78	**9808161.90**	
Supports Coordination Total:						**60785696.60**
Supports Coordination	15 minutes	18097	170.07	19.75	**60785696.60**	
Nursing Total:						**53166803.68**
Nursing	15 minutes	412	10258.00	12.58	**53166803.68**	
Therapy Services Total:						**207372.63**
Therapy Services	15 minutes	236	46.64	18.84	**207372.63**	
Supports Broker Services Total:						**35858.76**
Supports Broker Services	15 minutes	11	571.91	5.70	**35858.76**	
Assistive Technology Total:						**182107.97**
Assistive Technology	Outcome Based Unit	82	3.53	629.13	**182107.97**	
Behavioral Support Total:						**12107335.68**
Behavioral Support	15 minutes	3981	168.96	18.00	**12107335.68**	
Companion Total:						**13145221.69**
Base	15 minutes	0	0.00	1.09	**0.00**	
Level 1	15 minutes	0	0.00	1.26	**0.00**	
Level 2	15 minutes	34	2696.04	2.06	**188830.64**	
Level 3	15 minutes	782	4194.50	3.95	**12956391.05**	
Home Accessibility Adaptations Total:						**1189144.95**
Home Accessibility Adaptations	Outcome Based Unit	176	1.93	3500.78	**1189144.95**	
Specialized Supplies Total:						**18833.65**
Specialized Supplies	Outcome Based Unit	56	5.98	56.24	**18833.65**	
Transitional Work Services Total:						**7595706.52**
Base	15 minutes	328	3917.96	2.51	**3225578.11**	
Level 1	15 minutes	161	2598.77	3.35	**1401646.60**	
Level 2	15 minutes	189	1944.95	4.23	**1554929.18**	
Level 3	15 minutes	66	2007.26	10.67	**1413552.64**	
Transportation Total:						**11135110.19**

Transportation (Mile)	Mile	492	3270.81	0.56	**901173.57**	
Transportation (Trip)	Trip	819	353.56	25.77	**7462106.54**	
Per Purchase - Public Transportation	Outcome Based Unit	964	166.88	17.23	**2771830.07**	
Vehicle Accessibility Adaptations Total:						**303012.18**
Vehicle Accessibility Adaptations	Outcome Based Unit	43	1.75	4026.74	**303012.18**	

GRAND TOTAL:	**1897056030.16**
Total Estimated Unduplicated Participants:	**18097**
Factor D (Divide total by number of participants):	**104827.10**
Average Length of Stay on the Waiver:	342