

**SERVICES**



**PROGRAMS**



**WAIVERS**

## SERVICES / PROGRAMS / WAIVERS

List of the available Home and Community Based Programs and their associated eligibility requirements follows:

HCBS Program	Program Eligibility Requirements	Services Provided
<p style="text-align: center;"><b>MA 0192 Waiver for Persons with AIDS or Symptomatic HIV Disease</b></p>	<ol style="list-style-type: none"> <li>1. Diagnosed as having AIDS or Symptomatic HIV Disease Not enrolled in an MCO, HIO, or MA Hospice Program</li> <li>2. No in-hospital insurance, including Medicare</li> <li>3. Wish to be treated in own residence or other community setting</li> <li>4. Estimated cost of home or community care cannot exceed cost of inpatient institutional care</li> </ol>	<ul style="list-style-type: none"> <li>• Home health aide visits beyond those covered by Medical Assistance</li> <li>• Specialized medical equipment, supplies and nutritional supplements not covered by Medical Assistance</li> <li>• Nutritional consultations as needed and physician prescribed</li> <li>• Homemaker services</li> </ul>
<p style="text-align: center;"><b>Elwyn Waiver</b></p>	<ol style="list-style-type: none"> <li>1. Age 40 or older</li> <li>2. Residents of Delaware County and Valley View Assisted Living</li> <li>3. Meets nursing facility level of care criteria</li> <li>4. Deaf and/or deaf-blind</li> </ol>	<ul style="list-style-type: none"> <li>• Assisted Living Services: <ul style="list-style-type: none"> <li>○ Personal care</li> <li>○ Home health care</li> <li>○ Therapeutic, social and recreational programming</li> <li>○ Special medical equipment and supplies</li> <li>○ Transportation</li> <li>○ Counseling</li> </ul> </li> </ul>
<p><b>Michael Dallas Waiver Program for Technology-Dependent Individuals</b></p>	<ol style="list-style-type: none"> <li>1. Have exhausted private insurance</li> <li>2. In need of skilled care as determined by attending physician</li> <li>3. Technology-dependent</li> </ol>	<ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Respite services</li> <li>• Attendant care</li> <li>• Case management</li> <li>• Durable medical equipment</li> <li>• Medically necessary nutritional supplements</li> </ul>

<p><b>Home and Community-Based Services Waiver for Independence (OSP Independence Waiver)</b></p>	<ol style="list-style-type: none"> <li>1. Persons who have severe chronic physical disabilities which cause substantial functional limitations in at least three of these areas: <ul style="list-style-type: none"> <li>• Self care</li> <li>• Understanding and use of language</li> <li>• Learning</li> <li>• Self direction</li> <li>• Capacity for independent living</li> </ul> </li> <li>2. Must not be on a ventilator</li> </ol>	<ul style="list-style-type: none"> <li>• Service Coordination</li> <li>• Daily Living Services</li> <li>• Respite services <ul style="list-style-type: none"> <li>Routine wellness services</li> </ul> </li> <li>• Environmental accessibility adaptations</li> <li>• Specialized medical equipment and supplies</li> <li>• Personal Emergency Response Systems</li> <li>• Extended State Plan services</li> <li>• Visiting Nurse services</li> <li>• Community Integration Services</li> <li>• Education services</li> <li>• Transportation</li> </ul>
<p><b>Home and Community Based Waiver Program for Attendant Care Services (OSP/AC Waiver)</b></p>	<ol style="list-style-type: none"> <li>1. Between the ages of 18 and 59</li> <li>2. A medically determinable physical impairment which can be expected to last for a continuous period of not less than 12 months</li> <li>3. Capable of selecting, supervising, and if needed, firing an attendant</li> <li>4. Capable of managing their own financial and legal affairs</li> <li>5. Physical impairment which requires assistance to complete functions of daily living, self care and mobility</li> </ol>	<ul style="list-style-type: none"> <li>• Assistance with getting in and out of bed, wheelchair and/or motor vehicle</li> <li>• Assistance with performing routine bodily functions including, but not limited to: <ul style="list-style-type: none"> <li>○ health maintenance activities</li> <li>○ bathing and personal grooming</li> <li>○ eating, including meal preparation and cleanup</li> </ul> </li> <li>• Ancillary services <ul style="list-style-type: none"> <li>○ homemaker type services including but not limited to, shopping, laundry, cleaning and seasonal chores</li> <li>○ assistance with cognitive tasks, including but not limited to, managing finances, planning activities and making decisions</li> <li>○ companion type services such as transportation, letter writing, reading mail, and escort</li> </ul> </li> </ul>

<p><b>Home and Community Based Waiver Program for Individuals with Other Related Conditions (OSP/OBRA Waiver)</b></p>	<p>1. Persons with other related conditions - persons who have severe chronic physical disabilities which cause substantial functional limitations in at least three of these areas:</p> <ul style="list-style-type: none"> <li>• Self care</li> <li>• Understanding and use of language</li> <li>• Learning</li> <li>• Self direction</li> <li>• Capacity for independent living</li> </ul> <p>2. Must manifest their disability prior to age 22</p>	<ul style="list-style-type: none"> <li>• Service coordination</li> <li>• Daily living services</li> <li>• Routine wellness services</li> <li>• Respite services</li> <li>• Environmental adaptations</li> <li>• Assistive technology/specialized medical equipment and supplies</li> <li>• Personal Emergency Response System</li> <li>• Visiting Nurse services</li> <li>• Adult day health</li> <li>• Prevocational services</li> <li>• Educational services</li> <li>• Supported Employment services</li> <li>• Community integration services</li> </ul>
<p><b>Pennsylvania Department of Aging (PDA) Waiver</b></p>	<p>1. Aged 60 or older</p> <p>2. Meets nursing facility level of care criteria</p> <p>3. Wishes to be treated in own home or other community setting</p> <p>4. Can be served at a cost not to exceed 80 percent of the average MA payment for nursing facility services</p>	<ul style="list-style-type: none"> <li>• Adult Day Services Center</li> <li>• Attendant care</li> <li>• Counseling</li> <li>• Environmental modifications</li> <li>• Home health care</li> <li>• Home support</li> <li>• Specialized medical equipment and supplies</li> <li>• Personal Care services</li> <li>• Personal Emergency Response System</li> <li>• Extended physician services</li> <li>• Companion services</li> <li>• Respite services</li> <li>• Transportation</li> <li>• Home delivered meals</li> </ul>

<p><b>Long Term Care Capitated Assistance Program (LTCCAP)</b></p>	<ol style="list-style-type: none"> <li>1. Age 60 and over</li> <li>2. Dually eligible for Medical Assistance and Medicare</li> <li>3. Meet eligibility requirements for LTC facility level of care</li> <li>4. Able to live in community with services provided without jeopardizing health or safety</li> <li>5. Reside in locations where services are available</li> </ol>	<ul style="list-style-type: none"> <li>• All traditional Medical Assistance and Medicare services</li> <li>• Non-traditional services, including transportation, meals and friendly visits</li> <li>• Home care, home chore and personal care services</li> <li>• Adult Day Services</li> <li>• If the participant can no longer be cared for in the community, nursing facility placement will occur</li> </ul>
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## **What is Nursing Home Transition?**

Nursing Home Transition (NHT) is the process of assisting and empowering consumers who want to move from a nursing facility back to a home of their choice in the community. NHT activities include:

- Identifying individuals who want to move out of nursing facilities as consumers of the NHT Process
- Educating consumers and families so they have the information they need to make well-informed decisions about transitioning to the community
- Empowering consumers, so they are involved to the extent possible in planning and directing their own transition
- Connecting consumers to the services and resources they have identified and chosen as needed supports for living independently in the community
- Advocating for consumers to ensure that their transition plan is what they want and need, or providing them with the tools to be self-advocates if they so desire
- Supporting consumers and offering them the opportunity to discuss transition related issues with a peer. A peer is an individual who has experience in what consumers may be going through, either specific to transitioning from a nursing facility or specific to the disability.

## **Goals and Objectives**

- To help states like Pennsylvania rebalance their long-term living systems so that people have a *choice* of where they live and receive services. This will be done by *shifting funding* from institutions to home and community based services.
- To assist people in moving out of institutions – where they do not want to be – and providing an opportunity for them to live in the community, close to family and friends.
- To eliminate barriers in service systems so that individuals receive services and supports in settings of their choice.

## **Money Follows the Person**

Money Follows the Person, or MFP, is an exciting initiative utilizing the existing Nursing Home Transition Program to assist people who want to leave institutional care and receive services in their communities, closer to family and friends. If you know someone who lives in a nursing facility, institution for people with mental

retardation, or state hospital let them or their family know there are services available for them to successfully return to the community. By shifting funding from traditional institutional settings to home and community based services, people will be able to get the support they need to live independent and fulfilled lives.

**Money Follows the Person Rebalancing Demonstration**

- MFP is a federal initiative that will provide assistance to people who live in institutions so they can return to their own communities to live independently.
- The MFP initiative focuses on a number of different groups of people, including the elderly, individuals with physical disabilities, people with mental retardation or a developmental disability as well as people with mental illness.

**In order to qualify for Money Follows the Person, individuals must:**

- Have resided in a nursing facility, Intermediate Care Facility for Mental Retardation (ICF/MR) or state hospital for at least six months;
- Be actively receiving Medical Assistance or Medicaid benefits for at least 30 days;
- Be transitioning to a Qualified Residence, defined by federal government as:
  - A home owned or leased by the individual or the individual’s family member;
  - An apartment with an individual lease that has lockable doors (inside and out), and which includes living, sleeping, bathing and cooking areas over which the individual or the individual’s family has control;
  - A residence, in a community-based residential setting, in which no more than four unrelated individuals reside.
- Meet the eligibility criteria for one of the following state Home and Community Based waiver programs:

Aging Waiver	Attendant Care Waiver
Independence Waiver	COMMCARE Waiver
OBRA Waiver	Consolidated Waiver (ODP)

## **Domiciliary Care Program**

The Domiciliary Care or "Dom Care" program was created as part of Act 70 of June 1978 by the Commonwealth of Pennsylvania to provide a homelike living arrangement in the community for adults age 18 and older who need assistance with activities of daily living and are unable to live independently. Dom Care providers open up their homes to individuals who need supervision, support and encouragement in a family-like setting.

Dom Care residents are matched to homes that best meet their special needs, preferences, and interests. Dom Care homes are smaller than the traditional personal care home in that home providers care for no more than three Dom Care residents. Unlike larger personal care homes, Dom Care homes are the individual provider's home. They are inspected annually to ensure they meet health and safety standards. If the home and provider passes this inspection, they become "Certified".

Dom Care residents are adults age 18 or older, who cannot live independently, and generally are low in income. Most residents are either physically disabled, have demonstrated difficulties in social or personal situations that are usually associated with mental disability or mental retardation, or frail elderly persons. They must be willing to live with a family. Persons with extreme behavior problems or substance addictions are not appropriate for Dom Care.

Dom Care residents are not so functionally impaired as to need nursing home care and must be mobile or semi-mobile. Dom Care residents must be able to vacate the home in case of fire with minimal assistance. The local Area Agency on Aging will determine if a participant is appropriate for Dom Care.

Residents in the program receive much more than room and board. Residents receive supervision with self-help skills such as personal hygiene and grooming, three nutritious meals a day, and housekeeping and laundry services. If the resident takes medications, the home provider makes sure they get the correct dosage at the right times. Because of the small, homelike setting, Dom Care residents are assured of caring and individualized attention. Most importantly, Dom Care residents become part of a stable, caring "family" and can enjoy a sense of belonging and independence.

Dom Care residents that receive Supplemental Security Income (SSI) are also eligible for a state supplement towards the cost of Dom Care and a personal needs allowance. Residents receive on-going care management and monitoring, and involvement with day program activities is strongly encouraged.

The success of the Dom Care program is dependent on nurturing individuals who are willing to open up their home and willing to provide the support and care a Dom Care resident requires. Dom Care providers come from all walks of life. Some are widows or older couples. Others are families with young children, but all are willing to open their homes to people in need.

Dom Care home provider applicants go through an extensive certification process to ensure that homes meet the health and safety requirements as stated in the regulations. The local Area Agency on Aging is responsible for certifying Dom Care homes in their area. Some of these health and safety requirements of Dom Care providers include:

- Be at least 21 years of age
- Must own or rent your home or apartment
- Live in the certified home with the participant
- Show the results of a tuberculosis test or chest x-ray
- Hold current certification for both CPR and First Aid
- Have criminal history clearances
- Have satisfactory financial, medical, and personal references
- Work as a team member with care managers and participants

Dom Care residents enter into a contract to pay the home provider on a monthly basis for the entirety of the Dom Care residential service. Per regulation 21.41(6), the Pennsylvania Department of Aging is responsible for determining the monthly dollar amount the resident pays the provider. This rate applies to all Dom Care participants throughout the commonwealth. The rate usually increases every January 1 along with the annual increase in SSI. As of January 1, 2009, the monthly Dom Care payment for an individual is **\$936.00** and **\$1664.00** for an SSI couple who reside together in the Dom Care home.

## **Adult Day Services**

Adult day services provide a protective environment for older adults who are not capable of full-time independent living. Daily services such as socialization, recreation, nutrition, transportation, supervision, basic personal care, reality orientation, and self-help training can be found in most centers. The medical model can add physical therapy, occupational therapy, basic medical care, nursing care, and more intensive personal care.

Approximately 86% of all older people prefer to remain in their home in the company of family and friends as they age and daycare enables them to do that.

Additionally, this service provides a respite for caregivers enabling them to work outside of the home or to take a break from the daily rigors of 24 hour care giving, preventing caregiver burnout.

## **LIFE (Living Independence for the Elderly)**

LIFE is a managed care program for frail elderly recipients who have been determined to need "nursing facility level of care" but wish to remain in their home and community as long as possible. LIFE provides a comprehensive all-inclusive package of services to meet their needs. The program is known nationally as the Program of All-inclusive Care for the Elderly (PACE). All PACE providers in Pennsylvania have the name "LIFE" in their name. The first programs were implemented in Pennsylvania in 1998.

### **To be eligible a person must be:**

- Age 55 or older
- Nursing facility level of care eligible
- Eligible for Medical Assistance or able to private pay
- Reside in an area served by a LIFE provider
- Able to be safely served in the community as determined by a LIFE provider

### **Services that are available under the LIFE program include:**

- Primary Medical Care
  - Therapies
  - Personal Care
  - Pharmaceuticals
  - Recreational and Socialization Activities
  - Nursing
  - Monitoring
  - Meals
  - Transportation
  - Specialists
  - In-patient and Out-patient Hospital
  - Lab and X-ray
  - Eye glasses, hearing aides, and dentures
  - Emergency Care
  - Nursing Facility
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- The program is centered on an adult day health center where recipients receive most services.
  - Transportation is provided to and from centers and other services.
  - Home care is provided if needed

- If needed, home issues are identified and addressed to ensure safe home environment.
- If the participant experiences an acute episode, they are hospitalized.
- If the participant can no longer be cared for in the community, nursing facility placement will occur.
- All Medical Assistance services are arranged through the LIFE Providers.

## **OPTIONS PROGRAM**

The goal of the OPTIONS Program is to give choices to participants in need. The program provides an intensive assessment administered by staff from the Area Agency on Aging (AAA). Appropriate additional information is obtained from the participant's primary care physician. The assessment information is reviewed and care alternatives are identified and discussed with the participant. The participant's preference is considered along with service availability and when possible services are provided to the participant with full consideration of their desires.

Services range from those outside the home such as nursing facility or personal care residential home to a wide array of services in the participant's home such as home health, personal care, respite, environmental modifications, etc.

Participants who receive these services are normally sixty years of age or older and experience some degree of frailty in their physical or mental health status. They range in functional need from being clinically eligible for services in a nursing facility to needing basic personal care services such as assistance with bathing, dressing, grooming, etc.

With the exception of services funded through the Medicaid Program, there is no financial eligibility requirement for these services. However, there may be a co-pay requirement.

The availability of these services may vary from Area Agency on Aging to Area Agency on Aging. To determine appropriateness, co-pay, and availability please contact your local Area Agency on Aging.

The components of the OPTIONS Program are as follows:

### **Assessment:**

Assessment is the step taken by the AAA in partnership with the participant to determine or re-determine needs and how best the AAA can meet these needs. For other participants the assessment is performed to determine clinical nursing facility eligibility prior to the participant accessing a number of Medicaid funded programs. AAA's perform clinical Medicaid eligibility assessments under an agreement between the Department of Public Welfare (State Medicaid Agency) and the Department of Aging. Assessments are done annually to re-determine eligibility for the 60+ Medicaid Waiver and State Supplemented residents in personal care homes or domiciliary care homes.

- Determination of the need for and provision of services to persons over age 60 requesting the following Area Agency on Aging (AAA) services: day care, counseling, personal assistance services, home health, personal care, protective services, home-delivered meals, transportation services, respite care, home support services and any other AAA community or in-home service
- Care management to persons over age 60 with complex, ill-defined problems, problems remaining at home or requiring personal advocacy.
- Determination need for and provision of services and care management for the Medicaid waiver for over 60 persons requiring Nursing Facility Care.
- Assessment of persons ages 18 to 59 to determine nursing facility clinical eligibility for those persons looking to access Department of Public Welfare's Medicaid Home and Community Based Services Programs. AAAs also assesses participants under age 60 applying for the State Supplement for residents in personal care homes and domiciliary care.
- Mandatory assessment for persons applying for medical assistance (Medicaid) for nursing facility care or for placement in a domiciliary or personal care home who are eligible for the State Supplement to SSI;
- Assessment for any individual who is thinking about nursing facility care.
- The nursing facility assessment also includes screening for mental illness, mental retardation and other related conditions, and the assessment of need for specialized services.

**Program Eligibility Assistance:**

- Medicaid 60+ Waiver: If the participant (60 and older) is Medicaid eligible and the Area Agency on Aging has a service opening in the waiver, these services will be provided through the Medicaid 60+ Waiver.
- Aging Block Grant Services: If the participant (60 and older) is not Medicaid eligible, services are provided through the AAA block grant program if a service opening is available. The following services may be available in your local Area Agency on Aging planning and service area: Adult day care, counseling, personal assistance services, home health, personal care, protective services, home-delivered meals, transportation services, respite care, home support services.

- Family CareGiver Support Program: This program is designed to assist families and other unpaid primary caregivers caring for functionally dependent older persons and adult relatives with chronic dementia. The goal of the program is to reduce caregiver stress and burden through benefits and resources counseling, access to support groups, care giving skills training and education. This may include support and financial reimbursement for expenses incurred in purchasing care giving related services. Reimbursement benefits are subject to co pay and are based on household income and size where the care receiving resident resides.
- Care Management: Care Management is provided to most participants who receive Community Based Long Term Care Services. The AAA assigns a caseworker to the participant. The caseworker works with the participant/family to determine needs and how these needs are to be met. This is done through the use of a care plan that is tailored to the participant's needs as identified by assessment. The care plan is developed and implemented with the input of the participant. The caseworker orders the services and stays in contact with both participant and service provider to ensure the services are provided as ordered, and they are effective in meeting the participant's need.

## **THE ARRAY OF IN-HOME SERVICES MAY INCLUDE:**

### **Home Health Services:**

- Nurses aide services such as performing assistance with activities of daily living, simple measures and tests, assisting with ambulating, low level skin care, monitoring client condition, and other related services under the supervision of a registered nurse.
- Nursing services to include participant evaluations, development of a nursing plan, administration of physician prescribed medications, performing medical treatments as ordered by a physician, and performance of nursing duties as permitted under the Nurses Practice Act.
- Occupational therapy by a licensed therapist.
- Physical therapy by a licensed therapist.
- Speech therapy by a licensed therapist.
- Must be physician ordered. These services are normally paid for by Medicare, Medicaid or by another third party payer.

**Personal Assistance Services** for daily living assistance such as bathing, dressing, grooming, and ambulating aid.

**Home Support Activities** such as labor intensive maintenance, cleaning, home management activities, and some non-overnight companion service. This service is normally provided in conjunction with home health care or personal assistance.

**Medical Equipment, Supplies, and Adaptive Devices** may be purchased or rented as deemed appropriate by the Area Agency on Aging. As with home health services, this is normally paid for by Medicare, Medicaid or by a third party payer and require a physician's order.

**Overnight Shelter or Supervision** for the purpose of meeting a short-term need, or providing respite to caregivers.

**Environmental Modifications** completed for the purpose of making the home safe to live in.

**Counseling Services** by licensed or certified counselors for the purpose of assisting the participant to cope with daily living. This is normally paid for by Medicare, Medicaid or by a third party payer.

**Domiciliary Care** is a program that allows the AAA to place a participant in need of a living situation with personal care services. This is done after an assessment of need and a matching of the participant's need with available domiciliary care homes. The AAA per state regulations licenses domiciliary care homes. The Commonwealth also makes payment to the domiciliary care provider under an agreement with DPW and the Social Security Administration for participants who are eligible for Supplemental Security Insurance (SSI).

The AAA programs provide the participant a choice regarding the management of their service provider. The participant can choose to hire, fire, and supervise the provider or can transfer this responsibility to the AAA.

Examples of participant directed services are:

- The Department of Public Welfare Attendant Care Program. The Department of Public Welfare program is limited to participants under the age of sixty. On their sixtieth birthday they are transferred to the AAA Attendant Care Program. These are normally participants who have extensive personal care needs and have an attendant who spends a great deal of time with them meeting their needs. The attendant can provide any of the services referenced above.
- Personal Assistance Services (PAS) to participants those are very similar to Attendant Care recipients. The primary differences are participants

receiving these services did not come from the DPW program or due to changes in their needs have moved from attendant care to PAS. Their services are still provided by an attendant.

- The Provider Reimbursement Program allows the participant who is not in need of an attendant to also find individuals to provide their care. The care provider can provide the full array of services as referenced above. The primary difference from attendant care is this participant may have a single task oriented provider or multiple providers.

## **Services My Way**

Services My Way (SMW) promotes true participant control by offering alternatives to traditional services in which participants can manage their own flexible allowances to design and purchase disability-related goods and services. This model will allow participants to choose the goods and services they want, to direct as many of those services as they want, and to be the driving decision maker in ways that maximize their quality of life.

Based on their individualized budget, participants will develop their flexible spending plan to purchase goods and services. The flexible spending plan will allow participants to allocate money to hire their workers and to purchase goods and services.

SMW will provide a system of supports to assist participants in using self-directed services and provide protections and safeguards for both participants and state program agencies. Examples of types of support include: Information and Assistance in Support of Self Direction, Financial Management Services, and Care Manager or Service Coordinator.