

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

## **PURPOSE OF THE HCBS WAIVER PROGRAM**

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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**

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- 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:**  
**Independence Waiver**
- C. Waiver Number: PA.0319**  
**Original Base Waiver Number: PA.0319.**
- D. Amendment Number: PA.0319.R03.08**
- E. Proposed Effective Date:** (mm/dd/yy)

**Approved Effective Date: 01/01/13**  
**Approved Effective Date of Waiver being Amended: 07/01/10**

### **2. Purpose(s) of Amendment**

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**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:  
 Currently, waiver participants who self-direct some or all of their services receive Financial Management Services (FMS) as a waiver service. OLTL is amending the Independence Waiver to provide FMS as an administrative activity. OLTL has secured one entity to provide Financial Management services in all OLTL waivers across the Commonwealth effective January 1, 2013. Waiver participants enrolled in the Independence Waiver who self-direct some or all of their services will be transitioned to the selected vendor(s) by January 1, 2013.

In addition, OLTL is establishing a limitation on the number of participants served at any point in time for waiver years 3,4 and 5.

### **3. Nature of the Amendment**

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- 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)

<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	B-3-b
<input checked="" type="checkbox"/> Appendix C – Participant Services	C-3
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input checked="" type="checkbox"/> Appendix E – Participant Direction of Services	E-1-a, e, h, i, j, l, m; E
<input type="checkbox"/> Appendix F – Participant Rights	
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I – Financial Accountability	
<input type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	

**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:

Currently, waiver participants who self-direct some or all of their services receive Financial Management Services (FMS) as a waiver service. OLTL is amending the Independence Waiver to provide FMS as an administrative activity. OLTL has secured one entity to provide Financial Management services in all OLTL waivers across the Commonwealth effective January 1, 2013. Waiver participants enrolled in the Independence Waiver who self-direct some or all of their services will be transitioned to the selected vendor(s) by January 1, 2013.

In addition, OLTL is establishing a limitation on the number of participants served at any point in time for waiver years 3, 4, and 5.

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

### 1. Request Information (1 of 3)

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- 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):  
**Independence 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.0319**

Waiver Number: PA.0319.R03.08

Draft ID: PA.22.03.08

D. Type of Waiver (select only one):

E. Proposed Effective Date of Waiver being Amended: 07/01/10  
Approved Effective Date of Waiver being Amended: 07/01/10

### 1. Request Information (2 of 3)

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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 in 42 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**

**Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

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

### 1. Request Information (3 of 3)

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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 Eligibility 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

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**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 Independence Waiver provides services to adults with physical disabilities who are Medicaid eligible. The primary purpose of the waiver is to prevent inappropriate and unnecessary institutionalization by providing home and community-based services as a cost-effective alternative to institutional care. Independence Waiver services enable participants to:

- Live in the most integrated community setting appropriate to their individual service requirements and needs.
- Exercise meaningful choices.
- Obtain the quality services necessary to live independently.

Pennsylvania is committed to promoting participant choice, participant direction, and person-centered planning. This commitment is evident throughout the Independence Waiver application. The Independence Waiver allows Pennsylvania to provide an alternative to institutional care by offering home and community based waiver services to individuals who require a Nursing Facility (NF) level of care. Pennsylvania has demonstrated, through the Nursing Home Transition (NHT) Initiative, a commitment to continue the successful transition of individuals to the community. The Independence Waiver is an integral component of the NHT initiative.

The Office of Long-Term Living (OLTL) Bureau of Individual Supports (BIS) has administrative responsibility for the Independence Waiver. The BIS is also responsible for the administration of the Aids, Aging, Attendant Care, OBRA, and COMM CARE waivers.

## 3. Components of the Waiver Request

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**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

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- 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. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes
- If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):
- Geographic Limitation.** A waiver of statewide requirements 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 statewide requirements 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

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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

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*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 inpatients of a hospital, nursing facility or ICF/MR.
- 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:

Public Input for this waiver was obtained through the following means:

- The Community Life Advisory Committee (CLAC) provides ongoing feedback and communication regarding waiver issues. In addition to pointing out systemic problems with the waiver, the CLAC also recommends changes that would minimize the problems identified while ensuring that participant choice and control is always protected. The CLAC meets every other month and includes representation from participants, family members, advocates, and providers.
- The Provider Group offers input on the waiver, especially regarding waiver operations and provider capacity for services. This group is made up of representatives from provider agencies throughout the Commonwealth and meets quarterly
- The DPW Stakeholders' Planning Team (SPT) also provides ongoing input and feedback on departmental waivers and services.

The OLTL manages a website that offers program and contact information about the waivers.

- The Long Term Care Sub Committee and Consumer Sub Committee of the Medical Assistance Advisory Committee also provides ongoing input and feedback on departmental waivers and services.
- The DPW manages a website that offers program and contact information about the waivers. Stakeholders can contact the OLTL via the OLTLsupports email. These email messages go to the OLTL and are tracked to ensure follow-up and response.
- The OLTL has a toll-free hotline number (1-800-757-5042) that stakeholders can use to provide feedback on an ongoing basis. The hotline is staffed directly by the OLTL and calls are tracked.

**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)

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

<b>Last Name:</b>	Allen
<b>First Name:</b>	Leesa
<b>Title:</b>	Policy Director
<b>Agency:</b>	Office of Medical Assistance Programs, Department of Public Welfare
<b>Address:</b>	P.O. 2675
<b>Address 2:</b>	
<b>City:</b>	Harrisburg
<b>State:</b>	Pennsylvania

**Zip:**   
**Phone:**  **Ext:**   **TTY**  
**Fax:**   
**E-mail:**

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

**Last Name:**   
**First Name:**   
**Title:**   
**Agency:**   
**Address:**   
**Address 2:**   
**City:**   
**State:**   
**Zip:**   
**Phone:**  **Ext:**   **TTY**  
**Fax:**   
**E-mail:**

**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:**   
 State Medicaid Director or Designee  
**Submission Date:**

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

**Last Name:**

**First Name:** Vincent  
**Title:** Deputy Secretary  
**Agency:** Office of Medical Assistance Programs, Department of Public Welfare  
**Address:** P.O. Box 2675  
**Address 2:** Room 515, Health & Welfare Building  
**City:** Harrisburg  
**State:** Pennsylvania  
**Zip:** 17105-2675  
**Phone:** (717) 787-1870 **Ext:**  TTY  
**Fax:** (717) 787-4639  
**E-mail:** vingordon@pa.gov

### Attachment #1: Transition Plan

Specify the transition plan for the waiver:

### Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

### 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.

**Office of Long-Term Living**

(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 Office of Long Term Living (OLTL) operates as a unit within the State Medicaid Agency (SMA) and is responsible for oversight of all aspects of the Independence Waiver.

The Deputy Secretary of the Office of Long Term Living reports directly to the Secretaries of Aging and Public Welfare. The Secretary of Public Welfare is the head of the single state Medicaid agency. The Office of Long Term Living functions as part of both of the Departments of Aging and Public Welfare. The Secretary of Public Welfare, the State Medicaid Director and the Deputy Secretary of Long Term Living meet weekly to discuss operations of the waivers and other long term living programs. Therefore, the SMA through Secretary of Public Welfare has ultimate authority over operations of the waiver

- 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.:*

The Office of Long-Term Living contracts with the Area Agencies on Aging to perform Level of Care Assessments. In addition, effective July 1, 2010, the Office of Long-Term Living will be contracting with a non-governmental non-state entity to perform enrollment activities for the Independence waiver.

- 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

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- 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:*

OLTL retains the authority for all administrative decisions and supervision of non-state public agencies that conduct waiver operational and administrative functions.

A component of the Level of Care Assessment is contracted out to 52 local Area Agencies on Aging. 35 of the AAAs are non-state public agencies. A physician certifies level of care and the AAA completes the Level of Care Assessment (LOCA) form. The LOCA is designed to determine whether an individual is Nursing Facility Clinically Eligible (NFCE) or Nursing Facility Ineligible (NFI).

- 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:*

OLTL retains the authority for all administrative decisions and supervision of non-governmental non-state agencies that conduct waiver operational and administrative functions.

Enrollment - OLTL has state level oversight authority over the enrollment function. OLTL currently has agreements with enrolling agencies covering all 67 counties. Currently, 17 local enrolling agencies perform participant intake and enrollment functions. Local enrolling agencies consist of non-governmental non-state entities such as Centers for Independent Living, local United Cerebral Palsy offices, or local human services offices. The SMA recognizes that having the same local agency process a participant's waiver enrollment and also provide services to the same participant creates a conflict of interest.

OLTL has issued a Request for Proposal (RFP) for one independent entity to perform enrollment activities for all waivers managed by OLTL, with the exception of the Aging waiver. Effective July 1, 2010, the independent enrolling agency will handle waiver enrollments and will not provide any ongoing services to the participant.

A component of the Level of Care Assessment is contracted out to 52 local Area Agencies on Aging. 17 of the AAAs are non-state public agencies. A physician certifies level of care and the AAA completes the Level of Care Assessment (LOCA) form. The LOCA is designed to determine whether an individual is Nursing Facility Clinically Eligible (NFCE) or Nursing Facility Ineligible (NFI).

## Appendix A: Waiver Administration and Operation

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- 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:  
 Office of Long Term Living, Bureau of Individual Supports and Office of Quality Management, Metrics and Analytics.

## 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:

The Office of Long-Term Living (OLTL) oversees the performance of the enrollment function delegated to the Independent Enrollment Broker.

OLTL oversees the performance of the initial assessment functions that are delegated to the local Area Agencies on Aging (AAAs).

OLTL oversees the performance of the annual reevaluation function delegated to Service Coordination Agencies.

OLTL generates quarterly benchmark reports that measure timeliness of enrollment, level of care determinations, service utilization and other activities performed by contracted and Local/Regional Non-State Entities.

Quality Management Efficiency Teams (QMET) conduct bi-annual reviews of all providers. The QMETs review monitor providers performance and adherence to the waiver standards.

Ongoing monitoring of requirements for waiver eligibility, budgeting, provider enrollment and service delivery are completed electronically through the Home and Community Services Information System (HCSIS), and the Provider Reimbursement Operations Management Information System (PROMISE).

## 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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Number and percent of AAAs that meet waiver obligations regarding initial level of care determinations**

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input type="checkbox"/> Continuously and	<input type="checkbox"/> Other

	<b>Ongoing</b>	Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**

**Number and percent of Service Coordination agencies that meet waiver obligations regarding ongoing level of care determinations**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**

**Number and percent of contractual obligations met by the Independent Enrollment Broker**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____

<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 Quality Management Efficiency Teams (QMETs) are the State Medicaid Agency’s (OLTL) regional provider monitoring agents. The QMETs are comprised of one Program Specialist (regional team lead), one Registered Nurse, one Social Worker, and one Fiscal Agent. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator. Using a standard monitoring tool which outlines the provider qualifications as listed in the waiver, the QMET verify that the provider continues to meet each requirement during the review. During the provider review, a random sample of employee and consumer records are reviewed to ensure compliance with waiver standards. Each provider will be reviewed every two years, at minimum. Additionally, QMET conduct remediation activities as outlined in the waiver application.

For information regarding the Office of Quality Management, Metrics and Analytics (QMMA), and the Quality Improvement Strategy, please refer to Appendix H for detailed information.

**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.

When the administrative data and QMET monitoring reviews identify AAAs or SCAs that are not meeting the requirements related to Level of Care determinations as outlined in the waiver agreement, the agency receives written notification of outstanding issues with a request for a Standards Implementation Plan (STIP). The STIP is due to the QMET within 15 working days. QMMA staff reviews and accepts/rejects the STIP within 30 working days. Monitoring by the QMET occurs to ensure the Standards Implementation Plan was completed and successful in resolving the issue in accordance with the timeframes established for corrective action in the STIP. If the STIP was not successful in correcting the identified issue, technical assistance is provided by QMMA, Bureau of Individual Support and Bureau of Provider Support (BPS).

Through a combination of reports from the enrollment broker and administrative data, the Contract Monitor for the Independent Enrollment Broker (IEB) determines if the contractual obligations are being met. If they are not met, BIS notifies the IEB agency of the specific deficiencies, requests a corrective action plan and follows-up on the plan to ensure compliance.

- ii. **Remediation Data Aggregation**

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

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 a group 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 waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="radio"/> <b>Aged or Disabled, or Both - General</b>					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	18	60	
	<input type="checkbox"/>	Disabled (Other)			
<input type="radio"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/> <b>Mental Retardation or Developmental Disability, or Both</b>					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input type="radio"/> <b>Mental Illness</b>					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Individuals are able to enroll in the waiver up to age 60. Individuals that turn 60 while in the waiver, they are able to continue to receive services through the Independence Waiver.

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

1. Individuals who have a physical disability (but do not have a primary diagnosis of mental retardation or have a major mental illness), Likely to continue indefinitely.
2. Results in three or more Substantial functional limitations in major life activity; self-care, understanding and use of language, learning, mobility, self direction and/or capacity for independent living.

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

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

Individuals are able to enroll in the waiver up to age 60. Individuals that turn 60 while in the waiver, they are able to continue to receive services through the Independence Waiver.

## 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)

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**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	

	6007
Year 2	8000
Year 3	8000
Year 4	8000
Year 5	8000

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	0
Year 2	0
Year 3	7500
Year 4	7500
Year 5	7500

## 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	
Money Follows the Person	

## 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

**Purpose** (*describe*):

In order to ensure the success of the Money Follows the Person Rebalancing Demonstration,

Pennsylvania has reserved capacity within the Independence Waiver to serve participants in the demonstration. MFP participants will have access to all of the services available in the Independence Waiver.

**Describe how the amount of reserved capacity was determined:**

Reserved capacity was determined based on the experience in the state's Nursing Home Transition Program.

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

Waiver Year	Capacity Reserved
Year 1	57
Year 2	57
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

## 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:

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

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

1. Nursing Home Transition (NHT): Individuals who are currently receiving Medical Assistance in a nursing facility or those who are soon to be authorized for Medical Assistance and in a nursing facility and need waiver services to transition into the community.
2. Individuals who are at risk of nursing home placement. Individuals who currently reside in the community and are

at imminent risk of nursing facility placement within 24-72 hours or less.

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

## 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)**

- Low income families with children as provided in §1931 of the Act  
 SSI recipients  
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121  
 Optional State supplement recipients  
 Optional categorically needy aged and/or disabled individuals who have income at:

*Select one:*

- 100% of the Federal poverty level (FPL)  
 % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)  
 Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)  
 Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)  
 Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)  
 Medically needy in 209(b) States (42 CFR §435.330)  
 Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

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

Specify:

All other mandatory and optional groups under the State Plan are included.

---

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

---

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**
- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- A special income level equal to:**

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- A dollar amount which is lower than 300%.**

Specify 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:*

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**Appendix B: Participant Access and Eligibility**

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## 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:

- 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:

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

- The provision of waiver services at least monthly**
- Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

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

- Directly by the Medicaid agency**
- By the operating agency specified in Appendix A**
- By an entity under contract with the Medicaid agency.**

Specify the entity:

**Other**

Specify:

The Area Agencies on Aging (AAA) Assessors conduct the initial component of the level of care assessments for individuals referred for waiver services. In addition a physician (M.D or D.O) completes a level of care recommendation.

The Service Coordinators conduct the annual reevaluations for participants that are already enrolled in the waiver. Service Coordinators also conduct reevaluations more frequently, if needed.

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

AAA Assessors

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

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

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

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

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

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

Physicians

Licensed through the Pennsylvania Department of State under Chapter 17 of Title 49 PA Code.

- 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.

An individual is NFCE if he or she needs the level of care provided in a nursing facility.

Under Federal and State law and regulations, which identify the level of care provided in a nursing facility, a consumer should be considered NFCE if:

1. The consumer has an illness, injury, disability or medical condition diagnosed by a physician; and
2. As a result of that diagnosed illness, injury, disability or medical condition, the consumer requires care and services above the level of room and board; and
3. A physician certifies that the individual is NFCE; and

4. The care and services are either

a) skilled nursing or rehabilitation services as specified by the Medicare Program in 42 CFR §§ 409.31(a), 409.31(b) (1) and (3), and 409.32 through 409.35; or

b) health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program of health care and management and were previously available only through institutional facilities.

The Level of Care Determination is made using the Level of Care Assessment tool (LOCA) and a prescription.

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

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

Initial Level of Care Evaluation:

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

- The participant first applies for Independence Waiver services through the Independent enrolling agency. The role of the independent enrollment agency is to facilitate and support the participant through the enrollment process including the level of care evaluation. The enrolling agency follows the status of the level of care determination process and assists with any required communication between the participant, the participant's physician, and the AAA.
- The enrolling agency assists the participant with obtaining a completed prescription from the participant's physician (M.D. or D.O.)
- A physician completes a prescription form indicating the physician's level of care recommendation.
- The enrolling agency forwards the physician's prescription along with a request for a level of care assessment to the local Area Agency on Aging (AAA).
- The AAA assessor visits the participant and uses the "Level of Care Assessment" (LOCA) form to identify information regarding the participant's medical status, recent hospitalization, and functional ability (ADLs and IADLs).
- The AAA is responsible for making the final level of care evaluation decision.

Annual Reevaluation:

OLTL uses the following process for the annual reevaluation of current participants:

- The participant's Service Coordination agency is responsible for completion of the annual reevaluation of the level of care.

- The Service Coordinator completes the annual reevaluation by visiting the participant and completing a Reassessment Summary Form.
- The Reassessment Summary form mirrors the information collected in the LOCA, including information on medical changes, recent hospitalizations, and changes in functional status (ADLs and IADLs).
- The information collected on the Reassessment form is compared to the information collected in the individual's previous evaluation or reevaluation.
- The Service Coordination Agency is responsible for making the final level of care reevaluation eligibility decision.

OLTL maintains Administrative Authority over the evaluation and reevaluation processes by monitoring the timeliness and appropriateness of LOC evaluations and reevaluations. This is referenced in the Quality Improvement section.

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

- Every three months
- Every six months
- Every twelve months
- Other schedule

*Specify the other schedule:*

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

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

*Specify the qualifications:*

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

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

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

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

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

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

On an annual basis from the date the initial evaluation is completed the Service Coordinator will meet with the participant in their home to reassess the participant's need for waiver services and complete the Reassessment Summary Form. One month prior, the Service Coordinator will be alerted to the anniversary certification date through an automated notice from the Home and Community Services Information System (HCSIS). In addition, each Service Coordination agency maintains its own tickler system to complete timely reevaluations and maintain consistency in service.

After the reevaluation is completed, the Service Coordinator enters the information in a service note in HCSIS. The reevaluation information is maintained in the participant's file which is subject for review during OLTL annual monitoring visits.

- 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:

Home and Community Services Information System (HCSIS)  
 Service Coordinators maintain copies of evaluations in participant's record located at the Service Coordination agency.

## 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**
  - 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**  
**Number and percent of all new enrollees who have level of care determination, prior to receipt of waiver services**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative Data**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Twice a Year

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**  
**Number and per cent of waiver participants who received an annual re-determination of LOC within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC evaluation**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>

<input type="checkbox"/> <b>Continuously and Ongoing</b>
<input type="checkbox"/> <b>Other</b> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:  
Number and per cent of initial LOC determinations that adhered to timeliness and specifications**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

**Number and per cent of annual LOC determinations that adhered to timeliness and specifications**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative 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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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.  
Additional information on the Office of Quality Management & Analytics (QMMA) can be found in Appendix H.

**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.  
Subassurance a.i.a. In the course of the review by BIS of all new enrollees, if a new enrollee is identified who has an enrollment date prior to the LOC date, BIS notifies the enrolling agency of the need for correction, and follows and records the corrective action in the Service Plan tracking system.

If the Quality and Compliance Unit’s semi-annual review of LOC data in the Service Plan tracking system identifies non-compliance regarding LOC and enrollment date, a Quality Improvement Plan (QIP) is requested from BIS. More information on QIPs can be found in Appendix H.

Subassurance a.i.b. If non-compliance is determined, each Service Coordination Agency (SCA) is notified by the Quality and Compliance Unit (QCU) of the need for correction and verification of the correction. The

providers have 20 business days from receipt of the notification of the list of non-compliant records to correct, and return electronically verification of corrected records. QCU provides BIS and QMU with quarterly summaries of the notifications.

Subassurance a.i.c.If non-compliance is determined, each Area Agency on Aging (AAA) or SCA is notified by the Quality and Compliance Unit (QCU) of the need for correction (if data entry error) and verification of the correction. The AAA or SCA has 20 business days from receipt of the notification of the list of non-compliant records to correct, and return electronically verification of corrected records. QCU provides BIS and QMU with quarterly summaries of the notifications.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:  	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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).

PARTICIPANT FREEDOM OF CHOICE

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

The Commonwealth of Pennsylvania assures CMS that when a Nursing Facility (NF) or community resident applies for Independence Waiver services and the participant is determined to likely need the Nursing Facility Clinically Eligible (NFCE) level of care, the individual will be:

- Informed by the enrolling agency of any feasible service delivery alternatives available under the waiver; and,
- Given the choice of receiving NF institutional services, waiver services, or no services

#### Participant Freedom of Choice of Care Alternatives

All individuals who are determined to be eligible to receive community services in the waiver will be informed in writing, initially by the enrolling agency and ongoing by their Service Coordinator, of their right to choose between receiving home and community-based waiver services, Nursing Facility services, remaining in their present program, or receiving no services. All eligible participants will execute his/her choice by completing the OLTL Freedom of Choice Form.

The independent enrolling agency is responsible for ensuring that all individuals who are determined eligible for waiver services are given a list of all enrolled service coordination providers, and documenting the participant's choice of service coordinator on the OLTL Service Provider Choice Form. In addition, the enrolling agency is responsible for educating participants of their right to choose from any qualified provider, that they are not required to receive service coordination and service plan services from the same provider and that they have the right to change providers at any time. The enrolling agency will give each participant information about the Services and Supports Directory – a listing of all enrolled providers, which is maintained on HCSIS. Notation is made in the participant's record of receipt of the form; completed forms are maintained in the participant's file with the Service Coordination provider. OLTL monitors participant receipt of the forms as part of its bi-annual provider reviews.

The Service Coordination agency is responsible for ensuring participants are fully informed of their right to choose service providers before services begin, at each reevaluation, and at any time during the year when a participant requests a change of providers. The Service Coordination agency is responsible for providing the participant with the OLTL Service Provider Choice Form, and ensuring that the participant has reviewed and signed the form. Notation is made in the participant's record of receipt of the form; completed forms are maintained in the participant's file with the Service Coordination provider. OLTL monitors participant receipt of the forms as part of its bi-annual provider reviews.

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

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

## Appendix B: Participant Access and Eligibility

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### 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):

Waiver documentation is made available in different language upon request. If a specific language or interpreter is required, the Service Coordinators are instructed to call the Office of Long-Term Living. Language assistance will be provided without charge.

Each provider is required to have and implement policies and procedures for ensuring language assistance service to people who have limited proficiency in English.

## Appendix C: Participant Services

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### 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
Statutory Service	Personal Assistance Services
Statutory Service	Respite
Statutory Service	Service Coordination
Statutory Service	Supported Employment
Extended State Plan Service	Home Health
Supports for Participant Direction	Financial Management Services
Other Service	Accessibility Adaptations, Equipment, Technology and Medical Supplies
Other Service	Adult Daily Living
Other Service	Community Integration
Other Service	Community Transition Services
Other Service	Non-Medical Transportation
Other Service	Personal Emergency Repsonse (PERS)
Other Service	Therapeutic and Counseling Services

## 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:**

**Service:**

**Alternate Service Title (if any):**

**Service Definition (Scope):**

Education Services include:

- o Services that consist of courses that help the waiver participant in acquiring, re-learning or re-gaining skills and knowledge;
- o Services that may be offered in a number of different settings and may consist of general adult education services including applicable offerings at a community college, technical college, or a local educational facility.

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

EDUCATION SERVICES ARE NO LONGER AVAILABLE IN THE INDEPENDENCE WAIVER EFFECTIVE JUNE 1, 2012.

Education Services cannot be used to finance a college degree. Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under Section 110 of the Rehabilitation Act of 1973 or the IDEA.

The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

**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	School or Facility Program approved by the Department of Education to provide Education Services
Individual	Independent Education Instructor

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Education**

**Provider Category:**

Agency

**Provider Type:**

School or Facility Program approved by the Department of Education to provide Education Services

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Certified through the Department of Education

**Other Standard (specify):**

The individual education instructor and those individuals employed by the agency must meet the following:

- Be age 21 or older
- Hold a Bachelor's Degree with a current teaching certificate
- Have two years of experience teaching adult basic education
- Employees must have 2 years experience in teaching basic adult education

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL

**Frequency of Verification:**

Every Two Years

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Education**

**Provider Category:**

Individual

**Provider Type:**

Independent Education Instructor

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Certified through the Department of Education

**Other Standard (specify):**

The individual education instructor must meet the following:

- Be age 21 or older
- Hold a Bachelor's Degree with a current teaching certificate
- Have two years of experience teaching adult basic education
- Must have 2 years experience in teaching basic adult education

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL

**Frequency of Verification:**

Every Two Years

## Appendix C: Participant Services

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### 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:**

[Redacted]

**Service:**

Personal Care

**Alternate Service Title (if any):**

Personal Assistance Services

**Service Definition (Scope):**

Personal Assistance Services are aimed at assisting the individual to complete tasks of daily living that would be performed independently if they had no disability. These services include:

- Non-medical personal care (eating, bathing, dressing, personal hygiene), general household activities/chores (light housekeeping tasks, preparing meals, grocery shopping, laundry), cueing to prompt the participant to perform a task, and assisting a functionally impaired individual who cannot be safely left alone;
- Health maintenance activities provided for the participant, such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the individual's service plan;
- Routine wellness services to enable adequate nutrition, exercise, keeping of medical appointments and all other health regimens related to healthy living activities;
- Overnight Personal Assistance Services provide intermittent or ongoing, awake, overnight assistance to a participant in their home for up to eight hours. Overnight Personal Assistance services require awake-staff; and
- Chore services needed to maintain the home in a clean, sanitary and safe environment, such as washing floors, windows and walls, and tacking down loose rugs and tiles.

Personal Assistance Services is provided on a 1:1 basis.

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

Personal Assistance may be provided to escort participants to community activities or access other services in the community and be billed as personal assistance. Costs incurred by the personal assistance workers are not reimbursable under the waiver as Personal Assistance Services.

The scope of Personal Assistance Services may include performing incidental homemaker and chore services tasks. However, such activities may not comprise the entirety of the service. Chore services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision.

Personal Assistance Services cannot be provided simultaneously with Respite and home health aide services.

The frequency and duration of this service are based upon the participant's needs as identified and documented in

the participant's service plan.

**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	Home Care Agency
Individual	Individual PAS Worker

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Personal Assistance Services**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License** (specify):

Licensed by the PA Department of Health, per 28 PA Code Part IV, Subpart H, Chapter 611 (Home Care Agencies and Home Care Registries), under Act 69

**Certificate** (specify):

**Other Standard** (specify):

Agency:

- A signed Medical Assistance Provider Service Agreement with the State Medicaid Agency per 55 Pa Code, Chapter 1101

- Commercial General Liability Insurance
- Professional Liability Errors and Omissions Insurance
- Worker's Compensation Insurance, when required by Pennsylvania statute

Personal Assistance Services workers must:

- Be 18 years of age or older;
- Possess basic math, reading, and writing skills;
- Complete training or demonstrate competency by passing a competency test as outlined under 28 PA Code.
- Have the required skills to perform services as specified in the participant's service plan or receive necessary training to acquire the skill;
- Possess a valid Social Security number;
- Must pass criminal records check and child abuse clearances when applicable.

**Verification of Provider Qualifications**  
**Entity Responsible for Verification:**  
OLTL/Department of Health  
**Frequency of Verification:**  
Every Two Years/Every Two Years

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Personal Assistance Services**

**Provider Category:**

Individual

**Provider Type:**

Individual PAS Worker

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Personal Assistance Services workers must:

- Be 18 years of age or older;
- Possess basic math, reading, and writing skills;
- Possess a valid Social Security number;
- Submit to a criminal records check and child abuse clearances when applicable; and
- The Personal Assistance Services worker must be able to demonstrate the capability to perform health maintenance activities specified in the participant’s service plan or receive necessary training.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**  
Fiscal Employer Agent/OLTL  
**Frequency of Verification:**  
Every Two Years

**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:**

**Service:**

**Alternate Service Title (if any):**

**Service Definition (Scope):**

Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of those persons normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family, and are provided in quarter hour units. Respite services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power

of attorney, or reside in the home.

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

In-home Respite services cannot be provided simultaneously with Personal Assistance Services.

The frequency and duration of this service are based upon the participant’s needs as identified and documented in the participant’s service plan.

**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 Respite Worker
Agency	Home Health Agency
Agency	Home Care 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 Respite Worker

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Respite workers must:

- Be 18 years of age or older;
- Possess basic math, reading, and writing skills;
- Have the required skills to perform respite services as specified in the participant’s service plan;
- Possess a valid Social Security number;
- Submit to a criminal records check and child abuse clearances; and

The respite worker must be able to demonstrate the capability to perform health maintenance activities specified in the participant’s service plan or receive necessary training

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal Employer Agent/OLTL

**Frequency of Verification:**

Every Two Years

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. Chapter 601 and Subpart A. Chapter 51.

**Certificate (specify):**

Certification as required by 42CFR Part 484

**Other Standard (specify):**

Staff:

- A signed Medical Assistance Provider Service Agreement with the State Medicaid Agency per 55 Pa Code, Chapter 1101
- Must meet the requirements of 55 PA Code, Chapter 1249
- Supervision by a registered nurse
- Successful completion of a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e), or a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e).

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/PA Department of Health

**Frequency of Verification:**

Every Two Years/Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License (specify):**

Licensed by the PA Department of Health, per 28 PA Code Chapter 611 (Home Care Agencies and Home Care Registries)

**Certificate (specify):**

**Other Standard (specify):**

Agency:

- A signed Medical Assistance Provider Service Agreement with the State Medicaid Agency per 55 Pa Code, Chapter 1101
- Commercial General Liability Insurance

- Professional Liability Errors and Omissions Insurance
- Worker's Compensation Insurance, when required by Pennsylvania statute
- Must meet requirements of 55PA Code

Respite workers must:

- Be 18 years of age or older;
- Possess basic math, reading, and writing skills;
- Complete training or demonstrate competency by passing a competency exam as outlined in Sec 611.85 under Title 28, Part IV Subpart H of the Health Care Facilities Act
- Have the required skills to perform respite services as specified in the participant's service plan or receive necessary training;
- Possess a valid Social Security number;
- Must pass a criminal records check and child abuse clearances when applicable

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/PA Department of Health

**Frequency of Verification:**

Every Two Years/Every Two Years

## Appendix C: Participant Services

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### 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:**

[Redacted]

**Service:**

[Redacted]

**Alternate Service Title (if any):**

Service Coordination

**Service Definition (Scope):**

Service Coordination services are services that will assist individuals who receive waiver services in gaining access to needed waiver services and other State Medicaid Plan services, as well as medical, social, educational and other services regardless of the funding source. Service Coordination is working with the participant whenever possible to identify, coordinate, and facilitate all necessary services.

Service Coordination also includes: completion of needs assessment, advocacy, arranging for services from local resources, and coordination of services so a participant can realize his/her identified goals for living independently in the community.

Activities of a Service Coordinator include:

- o performing level of care re-determinations annually, or more frequently if needed;
- o maintaining current documentation of the participant's eligibility for waiver services, copies of the participant's service plan and service plan addendum, financial data and related information;
- o providing information and assistance to participants regarding self-direction;
- o informing participants of rights, responsibilities and liabilities when choosing a service model;

o monitoring the health and welfare of the participant and the quality of services provided to the participant through personal visits at a minimum of twice per year, telephone calls at least quarterly or as defined in the service plan – monitoring can be more frequent, but not less frequent than specified in this definition;

o providing notice of amount and frequency of waiver services;

o working with the participant to develop a comprehensive service plan – including risk identification – that meets their needs, preferences and goals;

o reviewing the service plan at least once a year or more frequently, if needed, as applicable to service provision; and

o ensuring that services are provided as planned and delivered appropriately to meet the participant’s needs.

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

The frequency and duration of service coordination is based upon the participant’s needs as identified and documented in the participant’s service plan. Service Coordination is limited to 144 units over a 12-month period. However, in order to meet the varying needs of individuals for service coordination services, this service limitation may be waived when reviewed and approved by OLTL.

Individuals aged 18 through 20 years of age are entitled to Case Management services under Pennsylvania’s Medicaid State Plan/MA Program.

**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	Service Coordination Agency

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Service Coordination**

**Provider Category:**

**Provider Type:**

Service Coordination Agency

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

Service Coordination Agencies must have:

- Sufficient professional staff to perform the needed assessment/reevaluation, service coordination

and support activities

- Registered nurse (RN) consulting services available, either by a staffing arrangement or through a contracted consulting arrangement

Service Coordinators must meet one of the following:

1. Have a bachelor’s degree including or supplemented by at least 12 college-level credit hours in sociology, social welfare, psychology, gerontology or another behavioral science
2. A combination of experience and training which adds up to four years of experience, and education which includes at least 12 semester hours of college-level courses in sociology, social work, social welfare, psychology, gerontology or other social science.
  - Experience includes: coordinating assigned services as part of an individual’s treatment plan; teaching individuals living skills; aiding in therapeutic activities; and providing socialization opportunities for individuals.
  - Experience does not include: providing hands-on personal care for individuals with disabilities or elderly; maintenance of an individual’s home, room or environment; and aiding in adapting the physical facilities of an individual’s home.

Service Coordination Supervisors must meet one of the following:

1. Have at least three years experience in public or private social work and a bachelor’s degree.
2. Have a combination of experience and education equaling at least three years of experience in public or private social work including at least 12 college-level credit hours in sociology, social work, psychology, gerontology or other related social science. Graduate coursework in the behavioral sciences may be substituted for up to two years of the required experience. Behavioral sciences include, but are not limited to, anthropology, counseling, criminology, gerontology, human behavior, psychology, social work, social welfare, sociology and special education.

A Service Coordinator must have at least 40 hours of training within the first year of employment.

The training shall include at least the following:

- Conducting a person-centered assessment
- Developing and modifying a participant’s service plan
- Utilizing the Department’s data systems
- Improving communication skills.
- Acquiring conflict resolution skills
- Completing documentation
- Understanding the disabilities of participants served

A Service Coordinator must have at least 20 hours of training annually that includes the training topics listed above.

Service Coordinators must pass criminal records check and child abuse clearances when applicable.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL

**Frequency of Verification:**

Every Two Years

**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:**

[Redacted]

**Service:**

[Redacted]

**Alternate Service Title (if any):**

**Service Definition (Scope):**

Supported employment services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular, integrated, competitive work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant, or supporting a participant to maintain a job.

Supported employment is conducted in a variety of settings, including work sites where persons without disabilities are employed. Supported employment can include employment in integrated work settings in which the participant is working toward competitive work.

Supported employment includes activities needed to sustain paid work by participants, including job coaches, job retention, individually tailored supervision and specialized job training. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

The individual is evaluated by the provider of employment services on a regular basis, at least quarterly, or more often based on the needs of the participant. The evaluation must include an assessment of the participant's progress, identification of needs and plans to address those needs. This evaluation shall be considered a part of the participant's service plan. It is the participant and supported employment services provider's responsibility to notify the Service Coordinator of any changes in the employment activities and to provide the Service Coordinator with copies of the referenced evaluation.

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

When Supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

Payments that are passed through to users of Supported employment programs; or

Payments for training that is not directly related to an individual's Supported employment program.

Waiver funding is not available for the provision of vocational services (e.g., sheltered work performed in a facility) where individuals are supervised in producing goods or performing services under contract to third parties.

The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

**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 Supported Employment Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agency:

- A signed Medical Assistance Provider Service Agreement with the State Medicaid Agency per 55 Pa Code, Chapter 1101
Commercial General Liability Insurance
Professional Liability Errors and Omissions Insurance
Worker's Compensation Insurance, when required by Pennsylvania statute
Must meet requirements of 55PA Code

Individual agency staff must:

- Be 18 years of age or older;
Have a high school diploma or GED and six months of paid or volunteer experience in working with people with physical disabilities and/or older adults
Have the required skills to perform the Supported Employment services specified in the participant's service plan
Have completed a service specific training program related to goals in the participant's service plan
Possess a valid Social Security number; and
Submit to a criminal records check and child abuse clearances

Verification of Provider Qualifications

Entity Responsible for Verification:

OLTL

Frequency of Verification:

Every Two Years

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:**

Home Health

**Service Definition (Scope):**

Nursing - services must be performed by an RN or LPN. 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 service 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." Services must be ordered by a physician and are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state. The physician's order must be obtained every sixty (60) days for continuation of service. Skilled nursing is individual, and can be continuous, intermittent, or part time nursing services based on individual's assessed need.

Physical Therapy - is provided by a licensed physical therapist or physical therapist assistant as prescribed by a physician, and documented in the service plan. The physician's order must be obtained every sixty (60) days for continuation of service. Per the Physical Therapy Practice Act (63 P.S. §1301 et seq.), physical therapy 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 - services are direct services provided to assist individuals in the restoration of a skill that the individual previously had but lost. Occupational Therapy can be provided by a licensed physical therapist or physical therapist assistant Services are provided as prescribed by a physician and outlined in a service plan. The physician's order must be obtained every sixty (60) days for continuation of service. 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. (4) Analyzing, selecting and adapting activities to maintain the individual's optimal performance of tasks to prevent disability."

Speech and Language Therapy - services are direct services provided to assist individuals in the restoration of a skill that the individual previously had, but lost. Services are provided as prescribed by a physician and outlined in a service plan. The physician's order must be obtained every sixty (60) days for continuation of service. Speech and Language Therapy services include the evaluation, counseling, habilitation and rehabilitation of individuals 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. Speech and Language Therapy services also include the examination for, and adapting and use of augmentative and alternative communication strategies.

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

Home Health services may only be funded through the waiver when the services are not covered by the State Medicaid Plan or private insurance. This may be because the State Medicaid Plan or insurance limitations have been reached, or the service is not covered under the State Medicaid Plan or private insurance.

Service is limited to needs determined during the assessment and identified in the participant's service plan.

**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	Licensed Practical Nurse
Individual	Registered Nurse
Agency	Out-Patient or Community-Based Rehabilitation Agency
Agency	Home Health Agency
Individual	Speech Therapist or Assistant
Individual	Physical Therapist or Assistant
Individual	Occupational Therapist or Assistant

## Appendix C: Participant Services

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

**Service Type:** Extended State Plan Service  
**Service Name:** Home Health

**Provider Category:**

**Provider Type:**

Licensed Practical Nurse

**Provider Qualifications**

**License** (specify):

Licensed under PA Department of State, per 49 PA Code Chapter 21 (State Board of Nursing)

**Certificate** (specify):

Certification as required by 42CFR Part 484

**Other Standard** (specify):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PA Department of State Board of Nursing

**Frequency of Verification:**

Every Two Years

## Appendix C: Participant Services

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

**Service Type:** Extended State Plan Service  
**Service Name:** Home Health

**Provider Category:**

Individual

**Provider Type:**

Registered Nurse

**Provider Qualifications**

**License (specify):**

Licensed under PA Department of State, per 49 PA Code Chapter 21 (State Board of Nursing)

**Certificate (specify):**

Certification as required by 42CFR Part 484

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PA Department of State Board of Nursing

**Frequency of Verification:**

Every Two Years

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Home Health**

**Provider Category:**

**Provider Type:**

Out-Patient or Community-Based Rehabilitation Agency

**Provider Qualifications**

**License (specify):**

Licensed by the PA Department of Health, per 28 PA Code

**Certificate (specify):**

Certification as required by 42CFR Part 484

Certified by CARF as a Medical Rehabilitation Provider

**Other Standard (specify):**

Meet 55 PA Code Chapter 1101

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PA Department of Health

**Frequency of Verification:**

Every Two Years

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Home Health**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. Chapter 601 and Subpart A. Chapter 51.

**Certificate (specify):**

Certification as required by per

42CFR Part 484

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/PA Department of Health

**Frequency of Verification:**

Every Two Years/Annually

**Appendix C: Participant Services**

---

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

---

**Service Type: Extended State Plan Service**

**Service Name: Home Health**

---

**Provider Category:**

Individual

**Provider Type:**

Speech Therapist or Assistant

**Provider Qualifications**

**License** (*specify*):

Licensed under the PA Department of State, per 49 PA Code Chapter 45 (Language and Hearing Examiner's Board)

**Certificate** (*specify*):

Certification as required by 42CFR Part 484

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PA Department of State Language and Hearing Examiner's Board

**Frequency of Verification:**

Every Two Years

**Appendix C: Participant Services**

---

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

---

**Service Type: Extended State Plan Service**

**Service Name: Home Health**

---

**Provider Category:**

Individual

**Provider Type:**

Physical Therapist or Assistant

**Provider Qualifications**

**License** (*specify*):

Licensed under PA Department of State, per 49 PA Code Chapter 40 (Physical Therapy Licensing Board)

**Certificate** (*specify*):

Certification as required by 42CFR Part 484

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PA Department of State Physical Therapy Licensing Board  
**Frequency of Verification:**  
Every Two Years

## Appendix C: Participant Services

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

---

**Service Type: Extended State Plan Service**  
**Service Name: Home Health**

---

**Provider Category:**

Individual

**Provider Type:**

Occupational Therapist or Assistant

**Provider Qualifications**

**License** (*specify*):

Licensed under the PA Department of State, per 49 PA Code Chapter 42 (Occupational Therapy and Education Licensing Board)

**Certificate** (*specify*):

Certification as required by 42CFR Part 484

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PA Department of State Occupational Therapy and Education Licensing Board

**Frequency of Verification:**

Every Two Years

## 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:**

Financial Management Services

**Alternate Service Title (if any):**

**Service Definition** (*Scope*):

Financial Management Services (FMS) provide payroll, invoice processing and payment, fiscal reporting services, employer orientation, and skills training, and other fiscal-related services to participants' choosing to exercise employer and/or budget authority within the Office of Long-Term Living (OLTL) programs and their representatives. FMS reduce the employer-related burden for participants while making sure Medicaid and Commonwealth funds used to pay for services and supports as outlined in the participant's individual service plan are managed and disbursed appropriately as authorized.

The FMS provider must operate as either a Vendor Fiscal/Employer Agent (F/EA) or as a Government Fiscal/Employer Agent (F/EA), in accordance with Section 3504 of the Internal Revenue Service (IRS) code and Revenue Procedure 70-6 and 80-4, respectively, as modified by IRS Proposed Notice 2003-70.

The F/EA must have an FMS policies and procedures manual, that includes the policies, procedures and internal controls that describe the proper operation of the F/EA, that are in accordance with federal, state, and local tax, labor, workers' compensation and program rules and regulations. When the F/EA is also a direct service provider, the F/EA must have documented policies, procedures and internal controls in place to ensure that participants have the right and ability to select the service provider of their choice.

Specifically, the government and vendor F/EA must :

- Be an enrolled provider in the Pennsylvania Medical Assistance Program;
- Meet the FMS provider qualifications as outlined in the OLTL F/EA FMS Provider Standards document;
- As a government or vendor F/EA, operate in compliance with the Standards as outlined in the Provider Standards document and maintain documentation to support its compliance with these standards;
- Meet the DPW's Standards for Provider Participation, Chapter 1101 of the Medical Assistance Regulations, and the Commonwealth's Contract Compliance Regulations set forth at 16 Pa. Code.§49.101 et.seq. This is to ensure the government or vendor F/EA has an administrative structure in place to effectively provide waiver services and to protect waiver service participants from neglect, abuse, and exploitation;
- Obtain written results of criminal history clearances from the Pennsylvania State Police for itself and all employees providing waiver/program services within 30 days from the date that the provider initiates services to the participant;
- As a government F/EA, operate in accordance with §3504 of the IRS code, Revenue Procedure 80-4, 1980-1 C.B. 581, as modified by IRS Proposed Notice 2003-70 and any other future revenue procedures, notices or publication promulgated by the IRS in the future;
- As a vendor F/EA, operate in accordance with §3504 of the IRS code, Revenue Procedure 70-6, 1970-1 C.B. 420, as modified by IRS Proposed Notice 2003-70 and any other future revenue procedures, notices or publication promulgated by the IRS in the future;
- Demonstrate the capacity to perform the required responsibilities through undergoing and passing the F/EA FMS Certification Review performed by the OLTL;
- Demonstrate continued capacity to perform the required responsibilities through undergoing and passing the annual F/EA FMS Recertification Review performed by the OLTL;
- Support the principles and philosophy of OLTL's home and community-based programs;
- Have management and line staff that are knowledgeable and have experience in providing FMS and working with persons with disabilities and chronic conditions;
- Have a sound financial and reporting structure to efficiently serve participants;
- Maintain books, records, documents, and other evidence of expenditures using generally accepted accounting principles (GAAP);
- Make all books, records, and documents available for inspection by the OLTL, Pennsylvania Department of Aging (PDA), DPW, or federal authorities without prior notice;
- Comply with all relevant state and local health and safety requirements;
- Demonstrate its capacity to develop and implement an information system to manage FMS-related records and files effectively;
- Conduct FMS activities separate and distinct from the direct care service delivery function if the organization is a direct care service provider and/or a supports coordination/care management provider for the OLTL;
- Demonstrate knowledge of and ability to stay current with federal, state and local tax, labor, workers' compensation insurance and program regulations related to the OLTL Programs, the delivery of F/EA FMS,

household employers, and domestic service workers

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

OLTL has secured one entity to provide Financial Management services in all OLTL waivers across the Commonwealth effective January 1, 2013. Waiver participants enrolled in the Independence Waiver who are self-directing some or all of their services will be transitioned to the selected vendor(s) by January 1, 2013.

The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

Financial Management Services is reimbursed on a per member per month basis with a one-time start-up fee for all new participants that enroll for Financial Management Services. The one-time start-up fee applies to new participants and will only be paid once in a lifetime per participant. The initial start-up fee covers the lengthy process of enrolling participants as a common law employee. The one-time start-up fee and the ongoing per member per month service fee may not be billed simultaneously.

**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	Vendor Fiscal/Employer Agent
Agency	Government Fiscal/Employer Agent

**Appendix C: Participant Services**

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

**Service Type: Supports for Participant Direction**  
**Service Name: Financial Management Services**

**Provider Category:**

Agency

**Provider Type:**

Vendor Fiscal/Employer Agent

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

Must meet all requirements of the Office of Long Term Living (OLTL) Fiscal/Employer Agent (F/EA) Financial Management Services (FMS) Provider Standards

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL

**Frequency of Verification:**

Upon initial enrollment

Every two years thereafter

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**

**Service Name: Financial Management Services**

**Provider Category:**

Agency

**Provider Type:**

Government Fiscal/Employer Agent

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Must meet all requirements of the Office of Long Term Living (OLTL) Fiscal/Employer Agent (F/EA) Financial Management Services (FMS) Provider Standards

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL

**Frequency of Verification:**

Upon initial enrollment

Every two years thereafter

## 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:**

Accessibility Adaptations, Equipment, Technology and Medical Supplies

**Service Definition** (*Scope*):

An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Items shall be specific to a participant's individual needs. Training to utilize adaptations, modifications and devices is included in the purchase as applicable. This service includes the following components:

- Accessibility adaptations to the participant's home, apartment, or other living arrangement in which the participant resides such as the participant's family's home, or the participant's friend's home, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home and are permanently attached to an individual's fixed environment. This service includes selecting, designing, customizing or replacing accessibility adaptations; evaluating the construction, provision or installation of accessibility adaptations during the adaptation and re-adaptation process; and providing post-installation visual inspections and ensuring that participants accept and can use their accessibility adaptations. Such adaptations include:

- o the installation of ramps and railings, the installation of specialized electric and plumbing systems that are

necessary to ensure the health and welfare of the participant and contribute to the participant's independence in everyday life, environmental and climate control units, automatic door openers and locks, speaker phones and intercom systems, special lighting devices, over-the-bed tables, stair glider, widening doorways and hallways, non-skid mats, stair strips and runners, wall protection strips and wall runners for wheelchairs, light switch adaptations or extensions, door knob extensions, smoke/fire alarm system adaptations;

o handrails and grab bars – such as those required in a bathroom, or in other areas of the home, modification of bathroom facilities, bath bench and bath lifts, stall adaptations – including roll-in showers and fixtures, fixture adaptations for sinks, showers or stoves, kitchen counter and cabinet modifications for participants who use wheelchairs; Rearrangement and new installation of plumbing, drains, electricity, and floor plans to permit least-cost, beneficial home modifications and assistive technology.

o rented property modifications must meet the following:

- there is a reasonable expectation that the participant will continue to live in the home;
- permission is secured from the property owner for the modification;
- indication of whether the owner will or will not require the home to be returned to its original state; and
- the landlord will not increase the rent because of repairs

o other modifications approved by OLTL as a part of an individual's service plan

All items shall meet applicable standards of manufacture, design and installation. Services will be provided in accordance with applicable federal, state and local building codes.

- Accessibility adaptations to the participant's vehicle, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the community. This service includes an evaluation of the needs of a participant, including a functional evaluation of the impact of the provision of appropriate adaptations to the participant's vehicle.

All items shall meet applicable standards of manufacture, design and installation.

- Specialized medical equipment, technology and supplies include:

o devices, controls, or appliances, specified in the service plan, that enable participants to increase, maintain, or improve their ability to perform activities of daily living;

o devices, controls, or appliances that enable, increase, maintain, or improve the ability of the participant to perceive, control, or communicate with the environment in which they live;

o items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

o such other durable and non-durable medical equipment not available under the State Medicaid Plan that is necessary to address participant functional capabilities; and

o necessary medical supplies not available under the State Medicaid Plan.

All items shall meet applicable standards of manufacture, design and installation.

- Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology service includes:

o the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

o services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

o services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

o training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

o training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

All items shall meet the applicable standards of manufacture, design and installation.

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

The accessibility adaptations, equipment, technology and medical supplies reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State Medicaid Plan and exclude those items that are not of direct medical or remedial benefit to the participant.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this service except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Any home or vehicle accessibility adaptation that exceeds \$6,000 requires a review by the State Medicaid Agency program office.

A vehicle cannot be older than 5 years, cannot have more than 50,000 miles, and is required to have passed a standard state inspection to be adapted.

Any specialized medical equipment, technology or supplies that exceed \$500 requires a review by the State Medicaid Agency program office.

This service does not include TeleCare Services.

The frequency and duration of this service are based upon the participant’s needs as identified and documented in the participant’s service plan.

**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	Pharmacy
Individual	Contractor
Agency	Durable Medical Equipment and Supply Company

**Appendix C: Participant Services**

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

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**Service Type: Other Service**

**Service Name: Accessibility Adaptations, Equipment, Technology and Medical Supplies**

---

**Provider Category:**

Agency

**Provider Type:**

Pharmacy

**Provider Qualifications**

**License (specify):**

|

**Certificate (specify):**

**Other Standard (specify):**

Meet state regulations under 55 PA Code 1123 regarding participation for medical supplies

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OHCD, OLTL

**Frequency of Verification:**

At time of service

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Accessibility Adaptations, Equipment, Technology and Medical Supplies**

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**Provider Category:**

Individual

**Provider Type:**

Contractor

**Provider Qualifications**

**License (specify):**

Contractor's license for state of Pennsylvania, if required by trade

**Certificate (specify):**

**Other Standard (specify):**

Individuals who provide accessibility adaptations must:

- be 18 years of age or older
- possess the trade-appropriate license
- have the skills required to perform the work

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OHCD, OLTL

**Frequency of Verification:**

At time of service

## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Accessibility Adaptations, Equipment, Technology and Medical Supplies**

---

**Provider Category:**

Agency

**Provider Type:**

Durable Medical Equipment and Supply Company

**Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Meet enrolled provider participation requirements as described in Chapter 1101 Medical Assistance

Provider participation requirement

Meet state regulations under 55 PA Code 1123 regarding participation for medical supplies

**Verification of Provider Qualifications****Entity Responsible for Verification:**

OHCDs, OLTL

**Frequency of Verification:**

At time of service

**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:**

Adult Daily Living

**Service Definition** (*Scope*):

Adult Daily Living includes two components: Basic Adult Daily Living services (full or half day) and Enhanced Adult Daily Living services.

Basic Adult Daily Living services are comprehensive services provided to meet the personal care, social, nutritional, therapeutic, educational, and recreational needs of individuals in a licensed center. Basic Adult Daily Living services can be provided as either a full day or a half day. The individual's service plan initiates and directs the services they receive while at the center. The services include:

- Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills;
- Personal care services such as activities of daily living (i.e., bathing, dressing, eating, mobility, and toileting) and instrumental activities of daily living (i.e., cooking, housework, and shopping), day respite services, and nursing services – the center staff who provide the hands-on assistance to the individual meet the minimum requirements of the service provider qualifications as if the services were stand-alone waiver services;
- Meals, including meals for special diets, and individual health education sessions based on the participant's needs – meals provided as part of this service shall not constitute a "full nutritional regimen" (3 meals per day);
- Transportation is included in the rated negotiated for Basic Adult Daily Living when no other source of transportation is available and the Basic Adult Daily Living service center provides the transportation.

Enhanced Adult Daily Living services are comprehensive services provided to meet the personal care, social, nutritional, therapeutic, educational, and recreational needs of individuals in a licensed center. Enhanced Adult Daily Living services are provided in a full day. The individual's service plan initiates and directs the services

they receive while at the center. Enhanced Adult Daily Living services also include the following additional service standards:

- **Nursing Requirement:** The Enhanced Adult Daily Living provider shall directly provide, contract for, or otherwise arrange for nursing services. In addition to the requirements found in the Older Adult Daily Living Center (OADLC) Regulations § 11.123 (2), a Registered Nurse (RN) must be available on-site one (1) hour weekly for each enrolled waiver participant. Each waiver participant at a minimum must be observed every other week by the RN with the appropriate notations recorded in the OADLC’s individual service plan with the corresponding follow-ups being made with the participant, family, or physician.
- **Staff to Participant Ratio:** Staffing of OADLC providing Enhanced Level of service will be at a staff to participant ratio of 1:5.
- **Operating Hours:** To be eligible for the minimum rate associated with Enhanced Services, the OADLC must be open a minimum of eleven hours daily during the normal work week. A normal work week is defined as Monday through Friday. (If open on a Saturday or Sunday the eleven hour requirement is not in effect for the weekend days of operation.)
- **Service definitions:** The guidelines for the required core services for the OADLC provider to include personal care, nursing, social, and therapeutic services, nutrition and therapeutic diets, and emergency care for participants can be found in OADLC Regulations, Subchapter A, and 11.123 Core Services.
- The guidelines for the required specialized services for the OADLC provider to include physical therapy, occupational therapy, speech therapy, and medical services can be found in Subchapter B, § 11.402.
- **Personal Hygiene:** Participants will receive whatever assistance necessary for the purpose of maintaining personal hygiene
- Transportation is included in the rate for Enhanced Adult Daily Living.

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

The individualized service plan will account for the services provided in the Adult Daily Living center and in the community/individual’s residence to ensure there is no duplication or excess of needed like-services.

Adult Daily Living services that include transportation cannot be provided simultaneously with Non-Medical Transportation.

The frequency and duration of this service are based upon the participant’s needs as identified and documented in the participant’s service plan.

**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	Adult Day Care Center
Agency	Older Adult Daily Living Center

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Adult Daily Living**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Care Center

**Provider Qualifications**

**License (specify):**

Meet licensing regulations under Title 55 PA Code, Chapter 2380, Subchapter A

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPW, Office of Administration, Human Services Licensing Management

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

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**Service Type: Other Service**

**Service Name: Adult Daily Living**

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**Provider Category:**

Agency

**Provider Type:**

Older Adult Daily Living Center

**Provider Qualifications**

**License (specify):**

Meet licensing regulations under Title 6 PA Code, Chapter 11, Subchapter A

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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**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:**

Community Integration

**Service Definition (Scope):**

Community Integration is a short-term, goal-based support service designed to assist participants in acquiring,

retaining, and improving self-help, communication, socialization and adaptive skills necessary to reside in the community. Community integration can include cueing and on-site modeling of behavior to assist the participant in developing maximum independent functioning in community living activities.

Community Integration is goal-based and situational to assist individuals in achieving maximum function during life-changing events such as a transition from a nursing facility, moving to a new community or from a parent's home, or a change in condition that requires new skill sets. Services and training must focus on specific skills and be related to the expected outcomes outlined in the participant's service plan.

Community Integration goals must be reviewed and/or updated at least quarterly by the Service Coordinator in conjunction with the participant to assure that expected outcomes are met and the service plan is modified accordingly.

Services must be provided at a 1:1 ratio.

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

Community Integration cannot be billed simultaneously with Personal Assistance Services.

Community Integration is reviewed quarterly to determine the progress of how the strategies utilized are affecting the participant's ability to independently complete tasks identified in the ISP. If the individual can complete the task independently, then the goal and CI service should be removed from the ISP. The length of service should not exceed thirteen (13) weeks on new plans.

If the participant has not reached the goal at the end of 13 weeks, then documentation of the justification for continued training on the desired outcome must be incorporated into the ISP at the time of the quarterly review.

If the participant has not reached his/her CI goals by the end of twenty-six (26) weeks, the goals need to change or it is concluded that the individual will not independently complete the goal and the SC must assess for a more appropriate service to meet the individual's need.

Each distinct goal may not remain on the ISP for more than twenty-six (26) weeks.

No more than 32 units per week for one CI goal will be approved in the ISP. If the participant has multiple CI goals, no more than 48 units per week will be approved in the ISP.

OLTL retains the discretion to 1) authorize CI for individuals who have not experienced a "life-changing event"; and 2) authorize more than 48 units (12 hours) of CI in one week for up to 21 hours per week and for periods longer than 26 weeks.

**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	Community Integration Agency

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Community Integration**

**Provider Category:**

Agency

**Provider Type:**

Community Integration Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Community Integration Agency Agency:

- A signed Medical Assistance Provider Service Agreement with the State Medicaid Agency per 55 Pa Code, Chapter 1101

- Commercial General Liability Insurance
- Professional Liability Errors and Omissions Insurance
- Worker's Compensation Insurance, when required by Pennsylvania statute
- Must meet requirements of 55PA Code

Individual agency staff must:

- Be 18 years of age or older;
- Have a high school diploma or GED and six months of paid or volunteer experience in working with people with physical disabilities and/or older adults
- Have completed a service specific training program related to goals in the participant's service plan.
- Have the required skills to perform the Community Integration services specified in the participant's service plan;
- Possess a valid Social Security number; and
- Submit to a criminal records check and child abuse clearances

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL

**Frequency of Verification:**

Every Two Years

## Appendix C: Participant Services

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### 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:**

Community Transition Services

**Service Definition** (*Scope*):

Community Transition Services are one-time expenses for individuals that make the transition from an institution to their own home, apartment or family/friend living arrangement. The funds may be used to pay the necessary expenses for an individual to establish his or her basic living arrangement and to move into that arrangement. The following are categories of expenses that may be incurred:

Equipment, essential furnishings and initial supplies. Examples—household products, dishes, chairs, tables;

Moving expenses;

Security deposits or other such one-time payments that are required to obtain or retain a lease on an apartment, home or community living arrangement;

Set-up fees or deposits for utility or service access, Examples – telephone, electricity, heating;

Personal and environmental health and welfare assurances, Example – personal health maintenance supplies, personal items for inclement weather, pest eradication, allergen control, one-time cleaning prior to occupancy.

The Transition Service Provider must keep a standardized record keeping system incorporating uniformity and consistency in service provision documentation and the participant’s response and observations.

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

Community Transition Services are limited to an aggregate of \$4,000 per participant, per lifetime, as pre-authorized by the State Medicaid Agency program office.

Expenditures may not include ongoing payment for rent.

This service does not cover those services available under “Accessibility Adaptations, Equipment, Technology and Medical Supplies”

The frequency and duration of this service are based upon the participant’s needs as identified and documented in the participant’s service plan.

**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	Service Coordination Agency
Agency	Transitional Service Provider

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Community Transition Services**

**Provider Category:**

Agency

**Provider Type:**

Service Coordination Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Service Coordination Agencies must meet all applicable federal or state requirements related to the service to be rendered.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/OHCDS

**Frequency of Verification:**

At Time of Service

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Community Transition Services**

**Provider Category:**

Agency

**Provider Type:**

Transitional Service Provider

**Provider Qualifications**

**License (specify):**

[Empty text box for license specification]

**Certificate (specify):**

**Other Standard (specify):**

Individuals who provide specific services such as pest eradication or allergen control must possess the required skill to perform the work and meet all local and state requirements in their trade.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/OHCDS

**Frequency of Verification:**

At Time of Service

**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:**

Non-Medical Transportation

**Service Definition (Scope):**

Non-Medical Transportation services are offered in order to enable participants to gain access to waiver services and other community activities and resources as specified in the service plan. This service is offered in addition to medical transportation services required under 42 CFR 440.170 (a) (if applicable), and shall not replace them. Non-Medical Transportation services include personnel costs for drivers and others to transport a participant and/or the purchase of tickets or tokens to secure transportation for a participant. Transportation needs and services must be reviewed and updated quarterly by the Service Coordinator.

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

Monthly transportation costs are capped at \$215 per person. Whenever possible, family, neighbors, friends or community agencies which can provide this service without charge should be utilized.

State Medicaid Plan transportation services will be used for obtaining State Medicaid Plan services. The individual's service plan must document the need for those Non-Medical Transportation services that are not covered under the Medical Assistance Transportation Program (MATP).

Non-Medical Transportation does not pay for vehicle purchases, rentals or repairs.

Non-Medical Transportation cannot be provided at the same time as Adult Daily Living services with transportation. Non-Medical Transportation cannot be provided simultaneously with Personal Assistance Services.

The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

**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 Driver
Agency	Licensed Transportation Agency, Public Transit Authority

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Non-Medical Transportation**

**Provider Category:**

Individual

**Provider Type:**

Individual Driver

**Provider Qualifications**

**License (specify):**

Valid Pennsylvania driver's license appropriate to the vehicle

**Certificate (specify):**

**Other Standard (specify):**

Drivers must meet the following:

- o 18 years of age
- o Must have appropriate insurance coverage (\$100,000/\$300,000 bodily injury)
- o Vehicles must be registered with the PA Department of Transportation
- o Receive physical examination (including a vision test) at the time of hire and at least every 2 years
- o Be willing to provide door-to-door services

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**  
OHCD  
**Frequency of Verification:**  
Prior to Service Approval

**Appendix C: Participant Services**

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

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**Service Type: Other Service**  
**Service Name: Non-Medical Transportation**

---

**Provider Category:**

Agency

**Provider Type:**

Licensed Transportation Agency, Public Transit Authority

**Provider Qualifications**

**License (specify):**  
Licensed by the P.U.C and/or be a Public Transit Authority, a Community Transportation Provider or Community Transportation Subcontractor  
**Certificate (specify):**

**Other Standard (specify):**  
Meet PA Vehicle Code (Title 75)

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**  
OLTL  
**Frequency of Verification:**  
Every Two Years

**Appendix C: Participant Services**

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**C-1/C-3: Service Specification**

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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:**

Personal Emergency Repsonse (PERS)

**Service Definition (Scope):**

PERS is an electronic device which enables waiver participants to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by

trained professionals, as specified. The PERS vendor must provide 24 hour staffing, by trained operators of the emergency response center, 365 days a year. Installation and maintenance are included in this service. All other medical equipment and supplies that will be of value to the participant to maintain safety in the home can be purchased using "Accessibility Adaptations, Equipment, Technology and Medical Supplies".

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

PERS services are limited to those individuals (1) who live alone, or who are alone for significant parts of the day and (2) have no regular caregiver for extended periods of time, or live with an individual that may be limited in their ability to access a telephone quickly when a participant has an emergency, and (3) who would otherwise require extensive routine monitoring and assistance.

Smoke detectors will not be billed under PERS. Smoke detectors will be billed under Accessibility Adaptations, Equipment, Technology and Medical Supplies.

PERS covers the actual cost of the service and does not include any additional administrative costs.

The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

**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	Durable Medical Equipment and Supply Company
Agency	Home Health Agency
Agency	Vendors of Personal Emergency Response Systems

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Personal Emergency Repsonse (PERS)**

**Provider Category:**

Agency

**Provider Type:**

Durable Medical Equipment and Supply Company

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

- o All PERS installed, shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply.

o Staff must be at least 18 yrs old

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/OHCDS

**Frequency of Verification:**

Upon Installation and Annually thereafter

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Personal Emergency Repsonse (PERS)**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities Subpart G. Chapter 601 and Subpart A Chapter 51

**Certificate (specify):**

Certification as required by 42CFR Part 484

**Other Standard (specify):**

o All PERS installed, shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply.

o Staff must be at least 18 yrs old

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/OHCDS

**Frequency of Verification:**

Upon Installation and Bi-annually thereafter

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Personal Emergency Repsonse (PERS)**

**Provider Category:**

Agency

**Provider Type:**

Vendors of Personal Emergency Response Systems

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

[Empty text box for certificate specification]

**Other Standard (specify):**

o All PERS installed, shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply.

- o Staff must be at least 18 yrs old

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/OHCDS

**Frequency of Verification:**

Upon Installation and Annually thereafter

## Appendix C: Participant Services

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### 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:**

Therapeutic and Counseling Services

**Service Definition (Scope):**

Therapeutic and counseling services are services that assist individuals to improve functioning and independence, are not covered by the State Medicaid Plan, and are necessary to improve the individual's inclusion in their community. Therapeutic and Counseling Services are provided by professionals and/or paraprofessionals in cognitive rehabilitation therapy, counseling, nutritional counseling, and behavior management. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

- Cognitive Rehabilitation Therapy services focus on the attainment/re-attainment of cognitive skills. The aim of therapy is the enhancement of the participant's functional competence in real-world situations. The process includes the use of compensatory strategies, and use of cognitive orthotics and prostheses. Services include consultation, ongoing counseling, and coaching/cueing performed by a certified Cognitive Rehabilitation Therapist.
- Counseling services are provided to participants in order to resolve individual or social conflicts and family issues. While counseling services may include family members, the therapy must be on behalf of the participant and documented in his/her service plan. Services include initial consultation and ongoing counseling performed by a licensed psychologist, licensed social worker, or licensed professional counselor.
- Nutritional Counseling services provided by a registered dietitian that are essential to the health and welfare of the participant. Services include initial consultation and ongoing counseling performed by a licensed and registered dietitian. Nutritional Counseling services are limited to 90-minutes (6 units) of nutritional consultations per month. Home Health Agencies that employ licensed and registered dietitians may provide nutritional counseling.
- Behavior Therapy services include the completion of a functional behavioral assessment; the development of an individualized, comprehensive behavioral support plan; and the provision of training to individuals, family members and direct service providers. Services include consultation, monitoring the implementation of the behavioral support plan and revising the plan as necessary. Behavior Therapy services are provided by a licensed psychologist, licensed social worker, behavior specialist or licensed professional counselor. A Masters level clinician without licensure, certification or registration, must be supervised by a licensed psychologist, licensed social worker, licensed professional counselor or licensed behavior analyst.

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

Participants must access State Plan services, including Outpatient Psychiatric Clinic Services, Outpatient Drug and Alcohol Services and services through the Behavioral Health Managed Care Organizations before accessing therapeutic and counseling services through the Independence Waiver.

Therapeutic and Counseling Services may only be funded through the waiver when the service is not covered by the Medicaid State Plan or private insurance unless the required expertise and experience specific to the disability is not available through the Medicaid State Plan or private insurance providers. This may be because the Medicaid State Plan or insurance limitations have been reached, or the service is not covered under the Medicaid State Plan or private insurance, or the provider does not have the expertise or experience specific to the disability. The Service Coordinator is responsible for verifying and documenting in the participant's file that the Medicaid State Plan and private insurance limitations have been exhausted or that the Medicaid State Plan or private insurance provider does not have the expertise or experience specific to the disability prior to funding services through the waiver. Documentation must be maintained in the individual's file by the Service Coordinator. This documentation must be updated annually.

The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.

**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	Licensed Psychologist
Individual	Licensed Social Worker
Individual	Licensed and Registered Dietitian
Agency	Home Health Agency
Individual	Cognitive Rehabilitation Therapist
Individual	Behavioral Specialist
Individual	Licensed Professional Counselor

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Therapeutic and Counseling Services

**Provider Category:**

Individual

**Provider Type:**

Licensed Psychologist

**Provider Qualifications**

**License** (specify):

Licensed by the State Board of Psychology Professional Psychologists Practice Act, 63 P.S. §§ 1201-1218, per 49 PA Code Chapter 41

**Certificate** (specify):

**Other Standard** (specify):

If drug abuse counseling is being provided the psychologist must have a minimum of six (6) months of professional experience providing substance abuse counseling

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/PA State Board of Psychology Professional Psychologists

**Frequency of Verification:**

Every Two Years/Every Two Years

**Appendix C: Participant Services**

---

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

---

**Service Type: Other Service**

**Service Name: Therapeutic and Counseling Services**

---

**Provider Category:**

Individual

**Provider Type:**

Licensed Social Worker

**Provider Qualifications**

**License (specify):**

Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 47

**Certificate (specify):**

**Other Standard (specify):**

If a licensed social worker provides drug abuse counseling he/she has a minimum of one (1) year of professional experience providing substance abuse counseling with the skills required as determined by the supervising psychologist.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/PA State Board of Social Workers, Marriage and Family Therapists and Professional Counselors

**Frequency of Verification:**

Every Two Years/Every Two Years

**Appendix C: Participant Services**

---

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

---

**Service Type: Other Service**

**Service Name: Therapeutic and Counseling Services**

---

**Provider Category:**

Individual

**Provider Type:**

Licensed and Registered Dietitian

**Provider Qualifications**

**License (specify):**

Licensed by the PA State Board of Dietitian-Nutritionists, per 49 PA Code Chapter 21

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/PA Department of State Board of Dietitian-Nutritionists

**Frequency of Verification:**

Every Two Years/Every Two Years

## Appendix C: Participant Services

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

---

**Service Type:** Other Service

**Service Name:** Therapeutic and Counseling Services

---

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License** (*specify*):

Licensed by the PA Department of Health, per 28 PA Code, Part IV, Health Facilities Subpart G. Chapter 601 and Subpart A. Chapter 51

**Certificate** (*specify*):

Certification as required by 42CFR Part 484

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/PA Department of Health

**Frequency of Verification:**

Every Two Years/Annually

## Appendix C: Participant Services

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

---

**Service Type:** Other Service

**Service Name:** Therapeutic and Counseling Services

---

**Provider Category:**

Individual

**Provider Type:**

Cognitive Rehabilitation Therapist

**Provider Qualifications**

**License** (*specify*):

Licensure specific to discipline

**Certificate** (*specify*):

Certified Brain Injury Specialist (CBIS); OR Certification by the Society for Cognitive Rehabilitation.

Certification or registration specific to discipline

**Other Standard** (*specify*):

Masters or Bachelors degree in an allied field with licensure, certification or registration where applicable. If credentialing is not available, a Bachelors or Masters degree professional must be supervised by a licensed psychologist, a Certified Brain Injury Specialist or a professional certified by the Society for Cognitive Rehabilitation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL

**Frequency of Verification:**

Every Two Years

## Appendix C: Participant Services

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

---

**Service Type: Other Service**  
**Service Name: Therapeutic and Counseling Services**

---

**Provider Category:**

Individual

**Provider Type:**

Behavioral Specialist

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Minimum of a Masters degree in Social Work, Psychology, Education, Counseling or related human services field. Individuals without licensure or certification must be supervised by a licensed psychologist, licensed social worker, licensed professional counselor or licensed behavior analyst.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL

**Frequency of Verification:**

Every Two Years

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## Appendix C: Participant Services

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

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---

**Service Type: Other Service**  
**Service Name: Therapeutic and Counseling Services**

---

**Provider Category:**

Individual

**Provider Type:**

Licensed Professional Counselor

**Provider Qualifications**

**License (specify):**

Licensed by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, per 49 PA. Code Chapter 49

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OLTL/PA State Board of Social Workers, Marriage and Family Therapists and Professional Counselors

**Frequency of Verification:**

Every Two Years

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## Appendix C: Participant Services

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### 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):

Effective July 1, 2008, criminal history background checks are required for all individuals performing personal assistance services. Individuals choosing to self-direct their services have the right to employ a worker regardless of the outcome of the background check. Participants using the Consumer Employer model of service may choose to have a criminal background check completed on individuals who were hired before the date of July 1, 2008.

The home care/personal assistance agency is responsible for securing criminal history background checks for their employees. The agency must have a system in place to document that the criminal history background check was conducted

The F/EA is responsible for securing criminal history background checks for prospective support workers. The cost of conducting criminal history background checks is included in the monthly per member per month rate paid to the F/EA. In addition, the F/EA must have a system in place to 1) document that the criminal history background check was conducted, and 2) the individual's decision to employ a support worker with a criminal record and their acceptance of responsibility for their decision.

Criminal history clearances are obtained from the Pennsylvania State Police within 30 work days from the date that the employee/provider initiates services to the participant. The Pennsylvania State Police access the Pennsylvania Crime Information Center (PCIC) and the National Crime Information Center (NCIC) for this information. In the interim of securing the written results of the criminal history, the agency will obtain a written certification from the employee which confirms that either the employee has never been convicted of a felony or discloses prior convictions.

The employee attests to understanding that if the certification is contradicted by the criminal clearance results,

the employee may face immediate dismissal from employment in the waiver program. The decision to dismiss an employee based on criminal background check results rests solely with the employer of record.

OLTL reviews provider personnel records as part of the annual monitoring to ensure that criminal history checks are documented.

- 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):

Written results of child abuse clearances are required for all direct care workers providing services in homes where children reside. These clearances are obtained from the Office of Children, Youth and Families, DPW-Childline and Abuse Registry, P.O. Box 8170, Harrisburg, Pennsylvania 17105-8170, (717)783-6211 within 30 work days from the date the employee/provider initiates services to the participant.

In the interim of securing the written results of child abuse clearances, the provider of service will obtain written certification from the employee which confirms that the employee has not, within five (5) years immediately preceding the date of enrollment into the waiver program been named on a central child abuse registry as being a perpetrator of founded or indicated child abuse.

The home care/personal assistance agency is responsible for securing child abuse clearances for their employees. The agency must have a system in place to document that the child abuse clearance was conducted.

The F/EA is responsible for securing child abuse clearances for prospective support workers. The cost of conducting child abuse clearances is included in the monthly per member per month rate paid to the F/EA. In addition, the F/EA must have a system in place to document that the child abuse clearance was conducted.

## Appendix C: Participant Services

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### 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).**

## Appendix C: Participant Services

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### 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.*

- 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.*

Personal Assistance Services workers may be members of the participant's family, excluding the following:

- The Independence Waiver will not pay for services furnished to a minor by the child's parent or step-parent, or by the participant's spouse.
- The Independence Waiver will not pay for services furnished by a legal guardian.
- The Independence Waiver will not pay for services furnished by a Representative Payee. This requirement may be waived under special circumstances, if reviewed and approved by OLTL.
- The Independence Waiver will not pay for services furnished by a Power of Attorney (POA). This requirement may be waived under special circumstances, if reviewed and approved by OLTL.

Family members who provide Personal Assistance Services must meet the same provider qualification standards as Personal Assistance Services workers who provide Personal Assistance Services to non-relatives.

Participants that employ family members to provide Personal Assistance Services must submit signed time sheets of service delivery hours to the F/EA. The F/EA reviews billable units through the Home and Community Based Services Information System (HCSIS). Reimbursement for services rendered is generated through the Provider Reimbursement Operations Management Information System (PROMISe).

Service delivery is monitored electronically through HCSIS and PROMISe to provide reimbursement for services approved in the participant's ISP. The F/EA will not pay for services that are not documented as necessary on the ISP.

- 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.

**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:

All willing and qualified providers have the opportunity to enroll as waiver providers at any time using the following process. OLTL has continuous open enrollment of providers and does not limit the application for provider enrollment to a specific timeframe. Copies of the forms for provider enrollment are available upon request from the OLTL, and are also available to potential providers online through the DPW website [www.dpw.state.pa.us](http://www.dpw.state.pa.us).

For an agency or individual provider to be enrolled as a new service provider they must contact OLTL. OLTL staff will guide the agency or provider of service in preparing an enrollment application. This application must be submitted to the OLTL for approval. The following documents must be completed as part of the enrollment application:

- 1) Provider Enrollment Information Form
- 2) Medical Assistance Provider Agreement
- 3) Rider A to the Medical Assistance Provider Agreement
- 4) Medicaid Home and Community Based Waiver Program Survey
- 5) PROMISe Enrollment Form

OLTL staff will provide technical assistance to the prospective provider in obtaining the appropriate documentation. Once OLTL receives a completed packet, OLTL staff will send a written response to the prospective provider within 60 days. The written response will include a request for more information, acceptance of enrollment, or denial of enrollment.

## 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**

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Number and Percent of newly enrolled providers who meet required licensure and initial QP standards prior to service provision**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>

	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

**Number and percent of providers continuing to meet applicable licensure/ certification and applicable waiver standards following initial enrollment**

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**  
**Number and percent of F/EA's who verified participant-employed attendant's qualifications**

**Data Source** (Select one):  
**Provider performance monitoring**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

**Data Aggregation and Analysis:**

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. **Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:**

**Number and percent of newly enrolled waiver providers who meet initial QP standards prior to service provision**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Number and percent of providers meeting provider training requirements**

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>

	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
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- 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 Quality Management Efficiency Teams (QMETS) are the State Medicaid Agency's (OLTL) regional provider monitoring agents. The QMETs monitor providers of direct services as well as agencies having delegated functions. The QMETs are comprised of one Program Specialist (regional team lead), one Registered Nurse, one Social Worker, and one Fiscal Agent. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator. Using a standard monitoring tool which outlines the provider qualifications as listed in the waiver, the QMET verify that the provider continues to meet each requirement during the review. During the provider review, a random sample of employee and consumer records are reviewed to ensure compliance with waiver standards, including provider training. Each provider is reviewed every 2 years, at a minimum. Additionally, QMET conduct remediation activities as outlined in the waiver application. The FEA verifies provider qualifications for consumer-employer model individual providers.

**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.

Subassurance a.i.a- Before a provider is enrolled as a qualified waiver provider; written documentation must be provided to the State QP Medicaid Agency (OLTL) of all state licensing and certification requirements. Additionally, a licensed or certified provider is required to submit written documentation that it meets initial qualified waiver requirements that are not part of its licensure or certification. When OLTL discovers an applicant provider does not meet licensure or certification requirements, the provider is not enrolled to provide services until the appropriate license or certification is obtained. When it is discovered that an existing provider is enrolled as a waiver provider, but has not obtained appropriate certification or licensure, OLTL sends a letter to the provider informing it of the need for the licensure or certification, and a blank Standards Implementation Plan (StIP) for the provider to complete. The letter warns the provider that it has no more than 30 calendar days to obtain appropriate licensure or certification before OLTL begins disenrollment procedures to terminate the provider as a qualified waiver provider. The provider must complete the StIP to concisely state how and when the provider will obtain the needed licensure or certification. The provider has 15 business days to submit its StIP to OLTL. OLTL reviews and approves the StIP within 30 business days of submission. If the StIP is insufficient; OLTL works with the provider to develop an appropriate StIP. If a staff member does not meet necessary state licensing or certification standards, the staff member cannot provide service to waiver participants until the provider verifies staff compliance with state licensing and/or certification requirements. The QMET verifies the approved StIP action steps are in place according to the timeframe written in the StIP. If the provider is unable or unwilling to obtain the appropriate license or certificate the provider is notified in writing by OLTL of its intention to dis-enroll the provider. The provider has the right to appeal.

Subassurance a.i.b- Upon application, OLTL reviews verification submitted by providers who are not required to receive a license or certification in order to provide services. OLTL verifies each provider meets the established criteria to be a qualified waiver provider. If a provider does not meet one or more of the waiver qualifications, OLTL notifies the provider of the unmet qualifications and provide information on available resources the provider can access to improve or develop internal systems to meet required provider qualifications. If a provider is unable to meet qualifications, the application to provide waiver services is denied

Within two years of becoming a waiver provider (and every two years thereafter), OLTL conducts a provider monitoring of each waiver provider to ascertain whether they continue to meet the provider qualifications, including training, outlined in this waiver. The Quality Management Efficiency Teams (QMETS) are the monitoring agent for OLTL. The QMET monitoring tool and database outlines each qualification a provider must meet. The qualifications are categorized according to provider type. Provider type is defined as the

service(s) the provider offers to waiver participants. The QMET monitoring tool and database collects the information discovered by the QMETs during reviews for data analysis and aggregation purposes. Through this process, if a QMET discovers a provider does not meet one or more of the qualifications, the provider, with technical assistance of the QMET, develops a Standards Implementation Plan (StIP). The provider needs to demonstrate through the StIP that it can meet the all waiver provider qualifications and develop a process on how to continue compliance in the future. The provider has 15 business days to submit a completed StIP to the appropriate regional QMET, and OLTL reviews and approves the StIP within 30 business days of submission. The QMET verifies the approved StIP action steps are in place according to the timeframe as written the StIP. If the StIP is insufficient; OLTL works with the provider to develop an appropriate StIP. If the provider is unable or unwilling to meet one or more of the waiver provider qualifications, the provider is notified in writing by OLTL of its intention to dis-enroll the provider. The provider has the right to appeal.

Subassurance a.i.c- The QMET monitoring tool ascertains if the provider has completed training in accordance with waiver requirements. OLTL directly supervises QMET activities through the QMET statewide coordinator to ensure that the state policies and procedures for verification that training is conducted in accordance with state and waiver requirements. If a QMET verifies training is not conducted, OLTL is made aware through the QMET tracking database. Each QMET reviews provider records to assure the training was completed according to waiver specifications. If a provider has not met training requirements, the provider is required to submit a StIP. The provider needs to demonstrate through the StIP that it can fulfill training requirements within 30 days of the QMET review. The provider has 15 business days to submit a completed StIP to the appropriate regional QMET, and OLTL reviews and approves the StIP within 30 business days of submission. The QMET verifies the StIP action steps are in place according to the timeframe as written the StIP. If the StIP is insufficient, OLTL works with the provider to develop an appropriate StIP. If the provider is unable or unwilling to resolve the deficiency in meeting one or more of the waiver provider training qualifications, the provider is notified in writing by OLTL of its intention to disenroll the provider. The provider has the right to appeal.

ii. **Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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

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### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

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### 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 D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**  
Individual Service Plan

- 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:*

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- Social Worker.**

*Specify qualifications:*

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- Other**

*Specify the individuals and their qualifications:*

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## **Appendix D: Participant-Centered Planning and Service Delivery**

### **D-1: Service Plan Development (2 of 8)**

- b. **Service Plan Development Safeguards.** *Select one:*

- 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:*

Service Coordination agencies are able to provide Community Transition Services to individuals transitioning from nursing facilities. Participants have the ability to choose from among all willing and qualified providers of Community Transition Services.

Service Coordination providers may also provide Financial Management Services to participants. Participants have the ability to choose from among all willing and qualified providers of Financial Management Services.

In addition, Service Coordination agencies may serve as an Organized Health Care Delivery System (OHCDS). Participants are not required to receive vendor services subcontracted through an OHCDS. Participants are able to select any qualified provider that has either contracted with the OHCDS or select any other qualified provider. The Service Coordination provider cannot require a participant to use their OHCDS as a condition to receive service coordination services from their agency.

Notation is made in the participant's record of receipt of the Service Provider Choice form. Completed forms are maintained in the participant's file with the participant's current Service Coordination provider. OLTL monitors receipt of the forms as part of its bi-annual provider reviews.

OLTL also provides a toll-free complaint line for participants to report concerns about their provider. This toll-free complaint line information is incorporated into the OLTL Service Provider Choice Form.

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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.

The Individual Service Plan (ISP) development process is a collaborative process between the participant and Service Coordinator. The participant drives the process and has the right to include family, friends, advocates or others as part of their ISP development.

A key step in developing the ISP is to complete the CMI, a standardized needs assessment which identifies the most appropriate services to address the participant's needs. The Service Coordinator gathers information from the participant, family, friends, advocates or others that are identified and chosen by the participant. If the participant uses an alternative means of communication or if their primary language is not English, the process utilizes the participant's primary means of communication, an interpreter, or someone identified by the participant that has a close enough relationship with the participant to accurately speak on his/her behalf.

When identifying services and supports, the participant and family, friends, advocates or others consider all available resources. The ISP includes informal supports in the participant's community, such as friends, family, neighbors, local businesses, schools, civic organizations, and employers.

Prior to the meeting(s), the Service Coordinator collaborates with the participant to coordinate invitations and ISP/Annual Review meetings, dates, times and locations. The process of coordinating invitations includes the participant's input as to who to invite to the meeting(s).

The Service Coordinator assists the participant in the development of the service plan.

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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):

The individual service plan (ISP), contains essential information about the individual, which is used for planning, and implementing supports necessary for the participant to successfully live the life that they choose. ISP's are based on written assessments or other documentation that supports the participant's need for each Waiver and Non-Waiver funded service in order to address the full range of individual needs.

-Who develops plan and participates in the process:

The participant's Service Coordinator develops the service plan utilizing a participant-centered approach. This process involves the Services Coordinator, the participant, and others as identified at the participant's request, such as family members or friends. The Service Coordinator educates the participant about services available through the waiver that would benefit or assist the participant in maximizing his/her independence. The Service Coordinator must discuss the participant's preferences and strengths including existing support systems and available community resources and incorporate those items into the ISP.

-The timing of the plan and how and when it is updated:

The Service Coordinator ensures that the ISP is updated, approved, and authorized as changes occur. The Service Coordinator ensures that the ISP is reviewed and updated at least annually with the reevaluation and if the participant's needs change. The Service Coordinator schedules the service planning meetings at times and places that are convenient to the participant.

The Service Coordinator gathers information on an ongoing basis to assure the ISP reflects the participant's needs. The Service Coordinator discusses potential revisions with the participant. When there is a potential change in the ISP, the Service Coordinator submits that change to OLTL through the Home and Community Based Information System (HCSIS) HCSIS. All changes to existing ISPs must be entered into HCSIS by Service Coordinators within three business days of identifying that the participant's needs have changed.

OLTL is responsible for the review and approval of plan changes. OLTL staff receives all ISP review alerts in HCSIS. OLTL staff reviews these alerts each work day and acts upon the alerts within 14 calendar days. OLTL staff may request additional details or ask for clarification regarding the information that the Service Coordinator provider includes in the HCSIS ISP and comments. If the ISP is authorized by OLTL, the Service Coordinator ensures that the service plan change or changes are communicated to the participant and shared with the participant's appropriate service provider or providers to ensure that service delivery matches the approved ISP. Changes to the ISP must be approved by OLTL prior to initiating changes in the service plan.

-The types of assessments that are conducted:

Part of the enrollment process involves the local Area Agency on Aging (AAA) assessor's completion of a LOCA tool to determine the participant's level of care. In addition a physician completes a prescription indicating the physician's level of care recommendation.

Once an individual has been enrolled in the Independence Waiver, the Service Coordinator completes a standard Assessment Summary form in conjunction with the participant and others at the participant's request. The Assessment Summary secures information about the participant's strengths, capacities, needs, preferences, health status, risk factors, and desired goals and outcomes. It also includes other necessary medical, functional, cognitive/emotional and social information used to develop the participant's ISP. The Service Coordinator uses the information gathered from the LOCA assessment and the standard Assessment Summary to develop the participant's Individual Service Plan.

The Service Coordinator also completes the Reevaluation Assessment Form annually or on an as needed basis to determine if the ISP requires any changes.

-How the participant is informed of the services available under the waiver:

The Service Coordinator is responsible to ensure all waiver participants are informed of home and community-based services funded through the Independence Waiver. The Service Coordinator describes and explains the concept of participant-centered service planning, as well as the types of services available through the Independence Waiver, to the participant at home visits and through ongoing discussions with the participant.

-How the process ensures that the service plan addresses participant's desired goals, outcomes, needs and preferences:

The Service Coordinator reviews the participant's assessed needs with the participant to identify waiver and non-waiver services that will best meet the individual's goals, needs, and preferences. In addition, Service Coordinators review with the participant their identified unmet needs and ensures that the service plan includes sufficient and appropriate services, and provides the support that an individual needs or is likely to need in the community and to avoid institutionalization.

The Service Coordinator utilizes the assessments and discussions with the participant to secure information about the participant's needs, preferences, goals, and health status to develop the Individual Service Plan. This information is captured by the Service Coordinator onto a standard service plan form and then documented in the Home and Community Services Information System (HCSIS). All service plan meetings and discussions with the participant are documented in the service notes.

The HCSIS ISP format stores information from the collaboration between the participant and Service Coordinator. Storing the plan electronically affords Service Coordinators, other designated providers and OLTL quick accessibility to information. The Service Coordination provider submits the ISP to OLTL through HCSIS. OLTL staff reviews HCSIS alerts each work day and acts upon the alerts within 14 calendar days. OLTL staff reviews the ISP. OLTL staff may request additional details or ask for clarification regarding the information that the Service Coordination provider includes in the HCSIS ISP and comments. If the ISP is authorized by OLTL, the Service Coordinator ensures that services are implemented at the local level. Participant service plans and the process of developing service plans are monitored by OLTL as listed in the Quality Improvement section of this Appendix.

The Service Coordinator gathers information on an ongoing basis to assure the ISP reflects the participants' needs. Revisions are discussed with the participant and entered into the ISP in HCSIS for OLTL review and if approved by OLTL, the updated service information is shared with the participant and service providers.

-How responsibilities are assigned for implementing the plan:

The Service Coordinator is responsible at least annually for developing ISPs by performing the following roles in accordance with specific requirements and timeframes, as established by OLTL:

- Completion of ISPs
- Entering ISP's into HCSIS
- Updating ISP's at least once every 365 days and whenever needs change
- Documenting contacts with individuals, families and providers
- Recordkeeping
- Locating services
- Coordinating service coverage through internal or external sources
- Monitoring services
- Ensuring health and welfare of waiver participants
- Follow-up and tracking of corrective action
- Completing assessments
- Sharing information
- Assuring information is in completed ISP
- Participating in ISP reviews
- Implementing recommended services
- Reviewing plan implementation

-How the process addresses participants' health care needs:

The Service Coordinator utilizes information gathered from assessments and discussions with the participant to secure information about the participant's health needs and health status. This information is captured onto a standard service plan form and then documented in the Home and Community Services Information System (HCSIS). A registered nurse is either on staff with the Service Coordination provider or is available under contract as a nursing consultant to the Service Coordination provider. The RN is required to review and sign the standardized needs assessment for individuals who are ventilator dependent, technology dependent, require wound care, are non compliant with medications, noncompliant with self-care or if the participant requests to have an RN involved with the assessment of needs. The Service Coordinator is responsible for notifying waiver participants that an RN is available should the participant wish to have a nurse included in the assessment process. This option is also incorporated into the standardized information packets that are distributed to all waiver participants. All service plan meetings and discussions with the participant are documented in the service notes.

-How waiver and other services are coordinated:

A team consisting of the participant, Service Coordinator, and others of the participant's choosing consider all other potential sources of coverage as part of the service plan development process. The team reviews for any service coverage that may be available under the State Plan or other possible Federal programs before utilizing waiver services. The team also reviews for the availability of informal supports in the person's community such as friends, family, neighbors, local businesses, schools, civic organizations and employers. Coordination of these services is guided by the principles of preventing institutional placement and protecting the person's health and welfare in the most cost effective manner. All identified services, whether available through the waiver or other funding sources, are outlined in the participant's ISP, which is distributed by the Service Coordinator to the participant and providers

of service. The Service Coordinator is responsible to ensure that there is coordination between services in the ISP, including maintaining collaboration between OLTL sponsored services and informal supports, as well as ensuring consistency in service delivery among providers.

-The assignment of responsibility to monitor and oversee the implementation of the service plan:

Upon authorization of the ISP, the Service Coordination provider must provide specific detailed information to service providers of the participant's choice regarding the type, scope, amount, duration, and frequency of the service authorized. Also included should be demographic information necessary for the delivery of the service (i.e. address, phone) and any information specific to the participant's needs and preferences that are directly related to the service being provided. The Service Coordinator must communicate service plan approval and changes to the participant and the appropriate service provider to ensure that service delivery is consistent with the approved ISP.

Service Coordinators are responsible for monitoring the health and welfare of the participant and the quality of the participant's service plan through personal visits at a minimum of twice per year and telephone calls at least quarterly. Service Coordinator monitoring ensures that reasonable safeguards exist for the person's health and well-being in the home and community. Personal visits and telephone contacts can be done more frequently as agreed upon by the participant to assure provision of services and health and welfare of the participant. Service coordinators are responsible for documenting the following:

- The participant is receiving the amount (units) of services that are in the ISP
- The participant is receiving the frequency of services that are in ISP.
- The participant receives the ordered services (scope-specific within the definition) that are in the ISP.
- The participant is receiving the duration of services that are in the ISP.

The Service Coordinator gathers information on an ongoing basis to assure the ISP reflects the participant's needs. Revisions are discussed with the participant and entered into the ISP in HCSIS and shared with the participant and service providers.

OLTL monitors ISPs as part of the annual monitoring for compliance with waiver requirements and ISP policies. OLTL also provides a toll-free complaint line for participants to report concerns about their provider. The toll-free complaint line information is provided at enrollment, at annual reevaluations, and during OLTL participant service monitoring visits.

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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 service plan assessment process includes the identification of potential risks to the participant. The Service Coordinator will discuss these potential risks with the participant and whomever the participant chooses to have present such as the participant's family and friends during the development of the ISP. The Service Coordinator, participant and other individuals chosen by the participant will identify strategies to mitigate such risks that will allow participants to live in the community while assuring their health and welfare. These strategies will be incorporated into the ISP. The Service Coordinator will also describe any unique circumstances on the service plan. The Service Coordinator will identify if any of the services available through the waiver would be appropriate for the participants' circumstances. The Service Coordinator will remain sensitive to the needs and preferences of the participant when identifying any risks or possible services that would assist the participant with addressing these risks. A specific service or combination of services may benefit the participant in these types of circumstances.

Currently, emergency back up plans and priority arrangements to ensure the health, safety and welfare of the participant are developed and documented during the ISP development process. Emergency back up plans are also part of the ongoing service plan monitoring process at the Service Coordinator level. All participants are required to have individualized backup plans and arrangements to cover services they need when the regularly scheduled service worker is not available. Strategies for back up plans may include the use of family and friends of the participants'

choice and/or agency staff, based on the needs and preferences of the participant. If the backup plan fails, participants may utilize the agency model to provide emergency backup coverage to meet their immediate needs. The Service Coordinator is responsible during regular monitoring to validate that the strategies and backup plans are working and are still current. To assist in assuring the health and welfare of the individuals, participants are instructed to contact Service Coordinators to report disruptions of backup plans and strategies.

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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.

At time of enrollment, the independent enrolling agency educates participants that they have the right to choose the providers of the services they will receive, including Service Coordination providers, and their right to choose a different provider for different services. Participants are free to change providers at any time by informing their Service Coordinator of the desire to make a change.

- Participants may also identify other non-waiver providers from whom they would like to receive services. This information will be given to the OLTL or designee who will make every attempt to recruit and enroll the provider in the waiver program.
- A current listing of enrolled providers is maintained by OLTL in the Services and Supports Directory. This listing is maintained in HCSIS and automatically updated as new providers are enrolled. The Services and Supports Directory is shared with participants by both the enrollment agency as well as service coordination providers.
- Participants are also given the toll free number of the Office of Long-Term Living (OLTL) so they may contact OLTL should they have concerns about their providers or questions regarding their ability to choose providers that provide the services in their service plan. The toll-free complaint line information is provided to participants at time of enrollment, at annual reevaluations, and during OLTL participant service monitoring visits.
- The enrolling agency is responsible for ensuring all individuals who are determined eligible for waiver services are given a list of all enrolled service coordination providers, and documenting the participant's choice of service coordinator on the OLTL Service Provider Choice Form.
- The Service Coordinator is responsible for ensuring participants are fully informed of their right to choose service providers before services begin, at each reevaluation, and at any time during the year when a participant requests a change of providers. The Service Coordination agency is responsible for providing the participant with the OLTL Service Provider Choice Form, and ensuring that the participant has reviewed and signed the form
- The OLTL Service Provider Choice Form emphasizes to participants that they have the right to choose any qualified provider, and that they cannot receive service coordination and service plan services from the same provider. The OLTL Service Provider Choice Form serves to document each individual's choice.

OLTL staff reviews service plan information in the Home and Community Services Information System (HCSIS). Service Coordination providers are required to confirm in HCSIS that the standard OLTL Service Provider Form has been completed whenever the Service Coordination provider submits a plan creation or plan revision to OLTL where the Service Coordination provider is also listed as the provider for other services on the plan.

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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):

OLTL as part of the State Medicaid Agency reviews and approves all service plans. The Service Coordinator, in conjunction with the participant, is responsible to modify the ISP if the participant's needs change.

When there is a change in the ISP, the Service Coordinator submits that potential change to OLTL through the Home and Community Based Information System (HCSIS). OLTL is responsible for the review and approval of ISP

changes in HCSIS.

The process of developing and revising service plans is monitored by OLTL as listed in the Quality Improvement section of this Appendix.

## 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.

The Office of Long Term Living (OLTL) as part of the State Medicaid Agency (SMA) is responsible for oversight of the monitoring and implementation of participant service plans.

At time of enrollment, the independent enrolling agency educates participants that they have the right to choose the providers of the services they will receive, including Service Coordination providers, and their right to choose a different provider for different services.

The Service Coordinator also has a local role in ensuring the implementation and monitoring of the ISP as follows:

- Ensures participant choice by providing information on available providers and supports participants in their decisions.
- Assists participants in gaining access to all necessary services.
- Works with the participant to identify, coordinate, and facilitate all necessary services.

- Assists with the coordination of other services from local resources to achieve maximum participant input and support.
- Monitors the health and safety of the participant and the quality of services provided to the participant through personal visits at a minimum of twice per year and telephone calls at least quarterly. Personal visits and telephone contacts may be done more frequently as agreed upon by the participant and team to assure provision of services and health and welfare of the participant.
- Addresses problems and concerns of participants on an as needed basis and report to OLTL with unresolved concerns.
- Initiates and oversees the process of reevaluation of the participant's level of care and review of ISP.
- Ensures that each participant has a comprehensive ISP that meets the identified needs of the participant and is implemented as indicated on the ISP.
- The service coordinator asks about the back-up at monitoring contacts. OLTL monitors for complaints about back-up plans through our complaint database and consumer satisfaction survey for additional information about the effectiveness of back-up plans.

OLTL reviews and approves the ISP through the Home and Community Services Information System (HCSIS). The Service Coordinator receives an alert of approval or disapproval from OLTL in HCSIS once the ISP is reviewed by OLTL staff. The Service Coordinator implements services if the ISP is approved by OLTL.

Any deficiencies or issues identified through the review of the ISP will be presented to the Service Coordination Agency for remediation. The Service Coordinator will be notified through communication from BIS in the comments section of HCSIS. BIS will expect the Service Coordination Agency to outline a plan to correct the issue(s) and submit to BIS for approval and follow up with notification of remediation. The plan should include communication strategies for notifying the participant of any service that may be affected due to the discrepancy or inappropriateness of the service they have coordinated.

The process for trending discovery and remediation information (data) begins with QMMA receiving the data from various points in the OLTL system. Database aggregations reports are created for QMMA to trend various aspects of quality including administrative authority, health and welfare, financial accountability, service plan development and implementation, level of care review, and provider qualifications. Additionally, the QMMA records information from field observations and record reviews to qualify the information gathered via administrative data. QMMA also relies on information provided by local non-state entities and the subsequent review of those entities to identify, track, and trend quality management issues.

**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:*

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## **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**
  - 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:**

**Number and percent of waiver participants who have Individual Service Plans (ISPs) that are adequate and appropriate to their needs, capabilities, and desired outcomes, as indicated in the assessment**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data</b>	<b>Frequency of data aggregation and</b>
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<b>aggregation and analysis</b> (check each that applies):	<b>analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <hr/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <hr/>

**Performance Measure:**  
**Number and percent of waiver participant satisfaction survey respondents who reported unmet need/needs**

**Data Source** (Select one):  
**Analyzed collected data (including surveys, focus group, interviews, etc)**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <hr/>
<input type="checkbox"/> <b>Other</b> Specify: <hr/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <hr/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <hr/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: <hr/>	

	Three times a year	
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**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Three times a year

**Performance Measure:**

Number and percent of waiver participants who have service plans that address the participant's goals as indicated in the assessment

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

- b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Number and percent of Individual Service Plans and related service plan activities that comply with who develops the plan, who participates in the process and the timing of the plan development.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

**Number and percent of Individual Service Plans and related service plan activities that comply regarding how waiver services and other non-waiver services are coordinated**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +\ -5%
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>

**Other**  
Specify:

**Performance Measure:**  
**Number and percent of Individual Service Plans and related service plan activities that comply with how the participant is informed of the services that are available under the waiver**

**Data Source (Select one):**  
**Record reviews, off-site**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>

<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**  
**Number and percent of waiver participants whose Individual Service Plan included a risk factor assessment and needs assessment instrument**

**Data Source** (Select one):  
**Record reviews, off-site**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Number and percent of Individual Service Plans (ISPs) reviewed and revised before the waiver participant’s annual review date**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
<input type="checkbox"/> <b>Other</b> Specify:		

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

**Number and percent of waiver participants whose Individual Service Plans (ISPs) was revised as needed, to address changing needs**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative Data**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Number and percent of waiver participants who received services in the type and amount specified in the Individual Service Plan.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b>	<input checked="" type="checkbox"/> <b>Annually</b>

Specify:	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**  
 Number and percent of waiver providers who delivered services in the type, amount, and frequency specified in the Individual Service Plan (ISP)

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**  
**Number and percent of waiver participant satisfaction survey respondents reporting the receipt of all services in Individual Service Plan (ISP).**

**Data Source (Select one):**  
**Analyzed collected data (including surveys, focus group, interviews, etc)**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Three times a year	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Three times a year

**Performance Measure:**

Number and percent of complaints received regarding non-receipt of services.

**Data Source (Select one):**

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

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**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Number and percent of waiver participants whose records contain appropriately completed and signed freedom of choice forms that specifies choice was offered between institutional care and waiver services.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**

**Number and percent of waiver participants whose records documented an opportunity was provided for choice of waiver services and providers**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

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.

See Appendix H for more information on QMMA.

**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.

If a waiver participant’s Individual Service Plan (ISP) is discovered to be deficient in accordance with the sub-assurances, the Bureau of Individual Supports (BIS) contacts the supervisor of the Service Coordinator/Care Manager responsible for the development of the ISP. The Service Coordinator/Care Manager and supervisors must have the deficiency corrected within 3 working days. If, through tracking and trending it is discovered that a specific provider has multiple deficiencies, the Quality Management Efficiency Team (QMET) are alerted. The QMET pulls a random sample of the provider’s records and review the ISPs to verify they meet participant needs adequately and appropriately. If the sample reveals a provider wide deficiency in developing an ISP which meets the subassurances, the provider must complete a Standards Implementation Plan (StIP) within 15 business days. OLTL reviews and approves the StIP within 30 business days of submission. If the StIP is insufficient, OLTL works with the provider to develop an appropriate StIP.

If the New or Annual Participant Satisfaction Survey responses indicate that waiver participants have unmet needs, QMMA initiates further analysis comparing with other data sources and develops a Quality Improvement Plan (QIP) or System Improvement Plan (SIP) if appropriate.

- ii. **Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:  	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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

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**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

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### 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.

#### Nature of the Opportunity:

All participants have the right to make decisions about and self-direct their own waiver services. Participants may choose to: 1) receive their services through the agency-managed model (Agency Model); or 2) hire and manage staff that performs personal assistance services (Employer Authority Model); or choose a combination of both Agency Model and Employer Authority Model services to meet their individual needs. Participants are encouraged to self-direct their services to the highest degree possible. During the actual provision of services, the participant is responsible for directing the activities of their personal assistant.

In the Agency Model, the direct service provider is responsible for hiring, firing, training, scheduling, all payroll tasks, and supervisory activities for each employee. Under the Employer Authority Model, the participant is the employer and is responsible for hiring, firing, training, supervising, and scheduling their personal assistants.

#### How Participants May Take Advantage of Participant Direction:

Participants may choose to self-direct their services during the development of the initial Individual Service Plan (ISP), at reassessment, or at any time. The participant's Service Coordinator will discuss the available service options and will ensure each participant understands the full range of opportunities with the waiver. The Office of Long Term Living has developed standardized educational materials and promotional materials with information about self-direction for all waiver participants.

As stated previously, the participant may utilize a combination of any model(s) to personalize their service delivery plan. The ISP is developed in conjunction with the Service Coordinator to ensure that the participant's service needs are met, and reflects the participant's choice of model of service. Service Coordinators shall offer all participants who have chosen to self-direct their services provider-managed services until the individual's support workers are hired. Participants may elect to change their service model at any time by notifying their supports coordinator.

#### Entities That Support Individuals:

Participants will receive support from certified Fiscal/Employer Agents and Service Coordinators to assist them in their role as the common-law employer of their workers. The Fiscal/Employer Agents will:

- Enroll participants in FMS and apply for and receive Federal and State Authority to act as a Government or Vendor F/EA on behalf of the participant;

- Provide participant orientation and skills training on required documentation for all directly hired support workers, including the completion of federal, state, and local tax forms; the completion of timesheets; good hiring and firing practices; effective management of workplace injuries; and informing workers of their right to file unemployment and workers compensation claims when appropriate;
- Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards;
- Conduct criminal background checks, child abuse clearances when applicable, on potential employees;
- Assist participants in verifying support workers' citizenship or alien status;
- Distribute, collect and process support worker timesheets as verified and approved by the participant;
- Prepare and issue support workers' payroll checks, as approved in the participant's Individual Service Plan;
- Compute, withhold, file, deposit, and track federal, state and local income taxes in compliance with all federal, state, and local requirements;
- Broker workers' compensation for participants in accordance with Pennsylvania workers' compensation insurance law;
- Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws;
- Process, file and distribute IRS Forms W-2's for all direct care workers and IRS Forms 1099-Misc as applicable, for independent contractors who earn more than \$600 in a calendar year;
- Assist in implementing the state's quality management strategy related to FMS;
- Establish and operate a customer service system that effectively serves participants, representatives, care managers/supports coordinators, direct care workers, providers and vendors in an efficient and effective manner.

In addition, individuals choosing the Consumer Employer Model will receive assistance from Service Coordinators to develop their Individual Service Plan (ISP). Once the ISP is developed, approved, and authorized, the participant is responsible for arranging and directing the services outlined in their plan. During the implementation and management of the ISP, the Service Coordinator will:

- Assist the participant to gain information and access to necessary services, regardless of the funding source of the services;
- Advise, train, and support the participant as needed and necessary;
- Assist the participant to develop an individualized back-up plan;
- Assist the participant to identify risks or potential risks and develop a plan to manage those risks;
- Monitor the provision of services to ensure the participant's health and welfare; and
- Assist the participant to secure training of support workers who deliver services that would require a degree of technical skill, and would require the guidance and instruction from a health care professional such as a Registered Nurse.

## Appendix E: Participant Direction of Services

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### 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 participants 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*

## 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.

The participant's Service Coordinator is responsible for presenting all available service options and ensuring that each participant understands the full range of participant direction opportunities within the waiver. The Service Coordinator documents the participant's choice on the ISP. Participants are also advised that they have the opportunity to change their model of service at any time throughout the year. Participants receive information about participant-direction on an annual basis and upon request.

The Office of Long-Term Living has developed consistent materials to inform current and prospective waiver participants about the benefits and potential liabilities of participant-direction. Participant materials include a comprehensive participant reference manual which contains details about participant-direction roles, responsibilities, and informed decision-making. These materials have been distributed to the Independent Enrollment Broker as well as all Service Coordination agencies, and are available on the OLTL website.

The F/EA is responsible for providing orientation and training to the participant prior to employing their direct care worker. Orientation is based upon a standard curriculum developed by OLTL and includes the following:

- Review of the information and forms contained in both the Employer and Direct Care Worker enrollment packets and how they should be completed
- The role and responsibilities of the common law employer;
- The role and responsibilities of the F/EA;
- The process for receipt and processing timesheets and employee payroll checks;
- The process for purchasing approved goods and services from vendors, including submitting invoices for payment;

- Effective practices for hiring, training, and supervising employees;
- The process for resolving issues and complaints; and
- The process for reviewing workplace safety issues.

## 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:

Waiver services may be directed by a non-legal representative freely chosen by an adult participant: A personal representative will be required for any individual who has impaired judgment as identified on the LOCA and/or is unable to:

- Understand his/her own personal care needs
- Make decisions about his/her own care
- Manage his/her lifestyle and environment by making these choices
- Understand or have the ability to learn how to recruit, hire, train, and supervise providers of care; or
- Understand the impact of his/her decisions and assume responsibility for the results.

The individual, a Service Coordinator, the OLTL, or the F/EA may request a personal representative be appointed, if indicated. A personal representative may be a legal guardian, or other legally appointed personal representative, an income payee, a family member, or friend. The personal representative must be willing and able to fulfill the responsibilities as outlined in the Personal Representative Agreement and must demonstrate:

- A strong personal commitment to the participant;
- Assist the participant in identifying/ obtaining back up services when a support worker does not show;
- Demonstrate knowledge of the participant's preferences;
- Agree to predetermined frequency of contact with the participant; and
- Be at least 18 years of age.

The Service Coordinator may request a personal representative be appointed when circumstances indicate a change in the participant's ability to self-direct or when the participant demonstrates misuse of funds, consistent non-adherence to program policy or an ongoing health and welfare risk.

A representative may not be a paid attendant for the participant. Each personal representative will be required to complete and sign a Personal Representative Agreement form.

## 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
Personal Assistance Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## 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 C1/C3**

**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:

Currently, waiver participants who self-direct some or all of their services receive Financial Management Services (FMS) as a waiver service from enrolled certified Vendor and Government Fiscal/Employer Agents. OLTL is amending the Independence Waiver to provide FMS as an administrative activity. OLTL has selected one qualified Vendor Fiscal Employer Agents to furnish Financial Management Services to participants across the Commonwealth through a competitive procurement process (RFA). Waiver participants enrolled in the Independence Waiver who self-direct some or all of their services will be transitioned to the selected vendor by January 1, 2013.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

- The selected vendor will receive a monthly per participant administrative fee for the FMS administrative service provided by the Vendor F/EA FMS. The monthly administrative fee is established as a result of the competitive procurement process. The selected vendor must apply the monthly per participant fee consistently with each participant enrolled with the vendor.

- A one-time start-up administrative fee is available for each participant for required activities related to the participant's enrollment with the selected vendor. The start-up administrative fee will be 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 DPW.

- DPW will pay the selected vendor a one-time per participant administrative transition fee to cover the

transition of current waiver participants from current FMS service providers to the selected vendor. This one-time per participant administrative transition fee will be implemented only during the transition period (December 1, 2012-December 31, 2012) and will be paid to the selected Vendor F/EA for the completion of all the required transition documents and activities in order for a participant to enroll with the new selected vendor. The one-time transition administrative fee is established by DPW.

The one-time per participant transition fee, the one-time per participant start-up fee and the ongoing per member per month administrative fee may not be billed simultaneously.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

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**Supports furnished when the participant is the employer of direct support workers:**

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- Assists participant in verifying support worker citizenship status**
- Collects and processes timesheets of support workers**
- Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- Other**

*Specify:*

- Enroll participants in FMS and apply for and receive Federal and State Authority to act as a Government or Vendor F/EA on behalf of the participant;
  - Provide participant orientation and skills training on required documentation for all directly hired support workers, including the completion of federal, state, and local tax forms; the completion of timesheets; good hiring and firing practices; effective management of workplace injuries; and informing workers of their right to file unemployment and workers compensation claims when appropriate;
  - Conduct criminal background checks, child abuse clearances when applicable, on potential employees;
  - Distribute, collect and process support worker timesheets as verified and approved by the participant;
  - Prepare and issue support workers' payroll checks, as approved in the participant's Individual Support Plan;
  - Compute, withhold, file, deposit and track federal, state and local income taxes in compliance with all federal, state, and local requirements;
  - Broker workers' compensation for participants in accordance with Pennsylvania workers' compensation insurance law;
  - Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws;
  - Process, file and distribute IRS Forms W-2's for all direct care workers and IRS Forms 1099-Misc as applicable, for independent contractors who earn more than \$600 in a calendar year;
  - Assist in implementing the state's quality management strategy related to FMS
- Establish and operate a customer service system that effectively serves participants, representatives, care managers/supports coordinators, direct care workers, providers and vendors in an efficient and effective manner.

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**Supports furnished when the participant exercises budget authority:**

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- Maintains a separate account for each participant's participant-directed budget**
- Tracks and reports participant funds, disbursements and the balance of participant funds**
- Processes and pays invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

*Specify:*

Additional functions/activities:

- Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

*Specify:*

- 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 statewide vendor F/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 OLTL Vendor F/EA contract requirements. The Vendor F/EA FMS provides specific employer agent functions that support the participant with the employer-related functions.

Through the OLTL Quality Management and Efficiency Teams (QMET), DPW will conduct a Readiness Review of the selected vendor prior to serving waiver participants. The purpose of the Readiness Review is to assess and document the status of the selected vendor's readiness to meet the requirements as outlined in the competitive procurement documents. In addition, OLTL will monitor the selected vendor to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. The statewide vendor will be monitored by QMET at a frequency established by DPW. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. SCs will also be required to report any issues with the statewide FMS organization's performance to OLTL.

Through the established claims oversight process, OLTL will monitor claim submitted by the Vendor F/EA to ensure the payments to the vendor for both administrative fees and services are in accordance with all applicable regulations and requirements.

## 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:*

- 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
Non-Medical Transportation	<input type="checkbox"/>
Personal Emergency Repsonse (PERS)	<input type="checkbox"/>
Education	<input type="checkbox"/>
Community Transition Services	<input type="checkbox"/>
Service Coordination	<input checked="" type="checkbox"/>
Adult Daily Living	<input type="checkbox"/>
Home Health	<input type="checkbox"/>
Therapeutic and Counseling Services	<input type="checkbox"/>
Personal Assistance Services	<input type="checkbox"/>
Financial Management Services	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Community Integration	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Accessibility Adaptations, Equipment, Technology and Medical Supplies	<input type="checkbox"/>

- 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:*

The Department of Public Welfare issued a Request for Application (RFA) to secure up to three entities that will provide Vendor F/EA FMS throughout the Commonwealth or on a regional basis for participants who receive participant-directed services in the OBRA waiver. One statewide vendor F/EA was selected as a result of the RFA.

The selected Vendor F/EA organization will receive a monthly per participant administrative fee for the FMS administrative service provided by the F/EA. In addition, a one-time start-up administrative fee is available for each participant for required activities related to the participant’s enrollment with the selected vendor. The initial start-up administrative fee will be authorized for each participant in the month prior to authorization of the ongoing monthly per participant administrative fee. The monthly administrative fee was established as part of the competitive procurement process; the one-time start-up administrative fee is established by DPW.

Participants will obtain enrollment and informational materials from the selected Vendor F/EA organization under contract with OLTL. In addition, the F/EA is responsible for providing orientation and training to the participant prior to employing their direct care worker. Orientation is based upon a standard curriculum developed by OLTL and includes the following:

- Review of the information and forms contained in both the Employer and Direct Care Worker enrollment packets and how they should be completed
- The role and responsibilities of the common law employer;
- The role and responsibilities of the F/EA;

- The process for receipt and processing timesheets and employee payroll checks;
- The process for purchasing approved goods and services from vendors, including submitting invoices for payment;
- Effective practices for hiring, training, and supervising employees;
- The process for resolving issues and complaints; and
- The process for reviewing workplace safety issues.

Through the OLTL Quality Management and Efficiency Teams (QMET), DPW will conduct a Readiness Review of the selected vendor prior to serving waiver participants. The purpose of the Readiness Review is to assess and document the status of the selected vendor's readiness to meet the requirements as outlined in the competitive procurement documents. In addition, OLTL will monitor the selected vendor to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. The statewide vendor will be monitored by QMET at a frequency established by DPW. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements.

## Appendix E: Participant Direction of Services

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### 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

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### 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:

Participants have the option to transition from participant direction to the provider managed service delivery model at any point during their waiver enrollment. When a participant voluntarily chooses to terminate participant direction, they will contact their Service Coordinator who will guide them through the process of transition. The Service Coordinator is responsible for transitioning the participant to the traditional model of service and ensuring that there is not a break in service during the transition period. The change in models will be reflected on a revised ISP.

## Appendix E: Participant Direction of Services

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### 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 provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants who demonstrate the inability to self-direct their services whether due to misuse of funds, consistent non-adherence to program policy or an on-going health and welfare risk, will be required to transition to provider managed services.

Involuntary Termination from participant direction may occur after it has been determined that there has been a negative impact on the participant’s health and welfare and/or services have not been provided as outlined in the ISP. Involuntary termination would only occur after a thorough review of the participant’s health and welfare needs as identified in the service plan.

Termination of participant direction would occur only after a team meeting with the participant, the participant’s Service Coordinator, and any family, friends and advocate if requested by the participant and a review of the recommendations by the OLTL.

The Service Coordinator is responsible for transitioning the participant to the traditional model of service and ensuring that there is not a break in service during the transition period.

The participant has the right to an Appeal and Fair Hearing and will be given this opportunity as outlined in Appendix F-1 Right to a Fair Hearing.

## 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

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
	Number of Participants	Number of Participants
Year 1	3127	
Year 2	3221	
Year 3	3318	
Year 4	3417	
Year 5	3520	

## 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:

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- 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:*

- Recruit staff**
- Refer staff to agency for hiring (co-employer)**
- Select staff from worker registry**
- 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:

To ensure all participants make informed choice of service and service delivery, criminal background checks are mandatory for individuals performing personal assistance services, hired after July 1, 2008. Participants may choose to have a criminal background check completed on individuals performing personal assistance services with an earlier date of hire. The FMS agency secures and pays for the criminal background check

- 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.**
- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- Determine staff wages and benefits subject to State limits**
- Schedule staff**
- Orient and instruct staff in duties**
- Supervise staff**
- Evaluate staff performance**
- Verify time worked by staff and approve time sheets**
- Discharge staff (common law employer)**
- 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:*

**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

- 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**
- Determine the amount paid for services within the State's established limits**

- Substitute service providers**
- Schedule the provision of services**
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- Identify service providers and refer for provider enrollment**
- Authorize payment for waiver goods and services**
- Review and approve provider invoices for services rendered**
- Other**

Specify:

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## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (3 of 6)

#### b. Participant - Budget Authority

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**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

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- 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.

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## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (4 of 6)

#### b. Participant - Budget Authority

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**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

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- 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.

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## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (5 of 6)

#### b. Participant - Budget Authority

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**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

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**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:

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## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

**b. Participant - Budget Authority**


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**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

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- 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:

---

## 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.

Participants are informed at the time of enrollment and at reevaluation that in order to request a fair hearing they should contact their Service Coordination provider. The independent enrolling agency and Service Coordination provider informs participants of the opportunity to request a fair hearing under the provisions of 42 CFR Part 431, Subpart E, to beneficiaries in the following situations:

1. when a participant is not given the choice of home or community-based services as an alternative to the institutional care
2. when a participant is denied the service(s) of their choice
3. when a participant is denied the provider(s) of their choice
4. any actions to deny, suspend, reduce, or terminate services
5. An individual also has the right to appeal the local enrolling agency's or Service Coordination provider's failure to act per

the Regulations at 55 PA Code §275.1(a) (i) (E). These regulations state that an individual may appeal an “undue delay in making a payment adjustment or acting upon a request or application.”

The independent enrolling agency is responsible for providing written notice to the individual when the individual is found ineligible for services. The enrolling agency issues a Notification of Eligibility Determination form to notify the participant of their right to a fair hearing and instructions on how the participant may request a fair hearing. The enrolling agency will retain copies of written notices at the local level.

The Service Coordination provider must send a written notice to the individual when services are denied, suspended, reduced, or terminated. The Service Coordination provider is responsible to provide the participant with at least ten days advance notice when an action will be taken regarding existing services that is subject to appeal. If the participant files an appeal prior to the date the action is to become effective, the services must continue pending the resolution of the appeal. If advance notice is not provided, the participant has the right to maintain services at the current level if the appeal request is made within ten days of the participant being informed of the action. A service that is denied prior to being included on an authorized service plan can be appealed, but is not subject to the continuation pending the appeal. The Service Coordination provider retains copies of written notices at the local level.

The Department of Public Welfare (the State Medicaid Agency) operates a comprehensive hearings and appeals process through the Bureau of Hearings and Appeals. When an appeal is received by the Bureau, it is docketed and scheduled for a hearing to be conducted by an Administrative Law Judge. When a hearing date has been assigned, a written notice is sent to both parties, i.e. the appellant and to the departmental program office. Either party to an applicant or recipient appeal may seek reconsideration by the Secretary of Public Welfare of the final order of the Director of the Bureau by requesting such within 15 calendar days from the date of the final order.

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.” This includes the independent enrolling agency and Service Coordination providers. The independent enrolling agency and Service Coordination providers are responsible for ensuring that individuals receive whatever help is needed to fill out and file the appeal form [see 55 PA Code §275.4(a)(1)]. Participants may also contact the Office of Long-Term Living directly. Participants are provided information about how to utilize the toll free helpline if they need assistance filing an appeal.

## 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.

## 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:

OLTL operates a toll-free complaint line, which is manned by Quality Management staff, for participants to report concerns.

- 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).

The OLTL operates a toll-free complaint line, which is manned by Quality Management staff.

All Hotline calls are responded to within one (1) business day. Calling the hotline is not a prerequisite for the participant to request a fair hearing. Participants are informed and notified of their right to appeal as a separate process from the hotline.

The types of complaints that can be addressed are:

- Complaints/grievances regarding provision and timeliness of services
- Reports of alleged abuse, neglect, or exploitation
- Status of waiver or program eligibility

The process used for operation of the complaint system:

OLTL takes calls on the toll free line. The OLTL call taker enters call information into the tracking data base. The OLTL call taker forwards grievances and complaints immediately to the appropriate OLTL Program Specialists for follow-up, research, and resolution. This information is also tracked in the data base. At a minimum, OLTL will initially respond to grievance and complaint calls within one business day. Additional follow-up and resolution timelines may vary depending on the issue or issues to be resolved.

Reports of potential abuse/neglect are followed up in accordance with OLTL Policy as outlined in Appendix G-1: 1-2 and G-2, Response to Critical Events or Incidents and Restrictive Interventions.

OLTL maintains a log to assure timely follow-up and unresolved issues are discussed and reviewed for resolution by appropriate OLTL staff. OLTL staff reviews all pertinent information with the participant, other OLTL staff, providers, or others as identified by the participant in order to resolve such complaints/grievances; at risk participant issues, and/or program issues as they arise.

Service Coordination providers inform and notify participants that their right to appeal is a separate process from calling the toll free hotline. Service Coordinators share this information during home visits and through ongoing discussions with the participant.

## 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).

The INDEPENDENCE Waiver participant, family members, service providers and others connected with the participant can report incidents to OLTL. Administrators and employees of home health care agencies and facilities are mandatory reporters of incidents as outlined in the OLTL incident management bulletin issued April, 2010.

The agency providing services to the INDEPENDENCE Waiver participant need to investigate potential incidents to determine if it meets one of the reportable categories below:

Reportable incidents or critical events include:

- 1) Death, Injury, or Hospitalization – any incident that occurred as a result of the provision of Home and Community-Based Services or lack of provision of documented services.
- 2) Provider and Staff misconduct – deliberate, willful unlawful or dishonest activities related to the provision of Home and Community- Based Services
- 3) Abuse – the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation on a participant.

Types of abuse include (but are not necessarily limited to):

- (a) physical abuse (a physical act by an individual that may cause physical injury to a participant);
- (b) psychological abuse (an act, other than verbal, that may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean a participant); i.e. gestures, facial expressions, menacing body language, etc.
- (c) sexual abuse (an act or attempted act such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and/or inappropriate or unwanted touching on a participant); and,
- (d) verbal abuse (using words to threaten, coerce, intimidate, degrade, demean, harass or humiliate a participant).
- 4) Exploitation – an act of depriving, defrauding or otherwise obtaining the personal property of a participant in an unjust or cruel manner, against one’s will, or without one’s consent or knowledge for the benefit of self or others.
- 5) Neglect – the failure to provide goods or services essential to avoid a clear and serious threat to the physical or mental health of a participant.
- 6) Service interruption -- Any event that results in temporary or permanent service interruption or termination by the service provider agency or staff that may place the home and community-based service participant at risk. In the event of temporary or permanent service interruption or termination, the service provider agency must have a plan for temporary stabilization.

The state prohibits the use of restraints and restrictive interventions within the INDEPENDENCE Waiver. The use of restraints or restrictive interventions is a reportable incident under the provider and staff misconduct category of reportable incidents.

Reporting process and timeframes:

Incidents are reported using an Incident Report form, emailing the report to an OLTL specified incident reporting email box.

All incidents where there is an interruption in services or the participant is at imminent risk must be reported within 24 hours. All other incidents must be reported within 48 hours. The service provider must forward to OLTL a follow-up related to the disposition of the incident report within five days of the initial report.

INDEPENDENCE Waiver participants and their representatives may notify their service providers or OLTL regarding any observed, alleged incident.

Direct service providers for INDEPENDENCE Waiver participants respond with appropriate immediate action and complete the OLTL Incident Report form and submit within two business days.

OLTL will follow-up with the INDEPENDENCE Waiver participant and service provider and investigate the specifics of the incident, including fact finding, the sequence of event, the potential causes and assess service planning to determine needed changes and documentation.

- 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.

OLTL provides information at enrollment and annual recertification of INDEPENDENCE Waiver participants concerning protections from abuse, neglect, and exploitation and how to report these incidents and upon request.

Participants and others may report incidents on the OLTL Participant Helpline which is a statewide toll free number that is available to program participants, legal representatives, personal assistants, and family members. The Participant Helpline number has been widely publicized and is included on the annual survey mailing described below.

OLTL annually surveys INDEPENDENCE Waiver participants and asks whether participants know how to report abuse, neglect, and exploitation. The surveys are reviewed for possible system improvements such as training or creating pamphlets for participants and families.

- 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.

OLTL's Quality, Metrics, and Analytics Office (QMMA) receives all reportable incidents submitted from any source.

QMMA is responsible for evaluating reports by reviewing all incidents received through the RA-Incident mailbox.

QMMA determines the Priority Level (urgent/non-urgent) and recommends the method/process of investigation such as:

Onsite investigation  
; Telephone investigation  
No further action

Investigation Priority:

- Non-Urgent –The details of the incident suggests an issue where the participants safety is not at risk and immediate attention is not required. The provider agency has initiated an investigation. The documentation reflects an investigative process is underway. Complete documentation is required within 5 business days.

- Urgent-The details of the Incident suggest immediate action is necessary to assist in safeguarding the participant's health and welfare. The investigative process/ documentation must be initiated within one business day.

Investigation Types:

- Onsite investigation- The provider and/or the participant onsite visit is conducted for fact finding. The incident facts, sequence of events, interview of witnesses and observation of the participant and/or environment is required. Onsite investigations will be conducted by OLTL staff when the incident places the consumer at immediate risk, and/or the incident investigation is lacking information or clarification is required and cannot be obtained through an alternative route.

- Telephone investigation- Review of the Incident Report (IR) revealed facts are missing or additional information is required and can be obtained through conducting a telephone investigation.

- No further action-: meets all of these 3 conditions:
  - 1) The facts and sequence of events is outlined with sufficient detail
  - 2) Preventative action through the service plan is implemented and documented
  - 3) The participant is not placed at any additional risk.

#### Incident Resolution:

The investigation of all incidents must be completed within 45 days of receiving the incident report. If the timeframe is not met the details regarding the delay will be documented in the incident reporting database. QMMA reviews and approves extension requests.

Incident resolutions are documented in the incident database for purposes of tracking and trending for quality improvement. Resolutions indicate the action provided to support the consumer, reduce the risk to the consumer, and/or initiate policy or protocol changes that will reduce risk or prevent reoccurrence of the incident. The following resolution categories are used:

- Adjusted Service Plan
- Agency protocols established or adjusted
- 
- Other (can be used in cases where the incident has no resolution, the narrative must support the decision).

The QMMA “Incident Reporting and Investigations” internal protocol outlines these responsibilities in more detail.

#### Service Coordinator Responsibilities:

- Follow up with direct service provider to ensure all appropriate actions have been taken.
  - Completes OLTL Critical Incident Report Form and submit to OLTL within the timeframes outlined in the OLTL Incident Management Policy if not already submitted by the direct service provider.
  - Completes an initial investigation to determine specifics of incident to include: fact finding, identify the sequence of events, identify potential causes, and assess service planning to determine any needed changes and documentation.
  - Conduct initial investigation of the incident and provide a report to OLTL within 5 business days of the occurrence. When unable to conclude initial investigation within 5 days, request an extension from OLTL/QMMA through the RA-Incident@state.pa.us, mail box in writing.
- 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.

The Office of Long-Term Living maintains a statewide database on all participants who were referred for investigation of an incident. Reports related to incidents are run monthly, quarterly and annually. The results are aggregated for tracking and trending purposes to detect patterns for possible remediation. The results of the reports are presented at the Quarterly Quality Management Meetings (QM2) and the Quality Council which meeting quarterly to discuss and recommend quality improvement measures.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

#### a. Use of Restraints or Seclusion. *(Select one):*

- The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

During enrollment and at reevaluation the Service Coordination Agency reviews the process for reporting the use of Restraints and Restrictive Interventions with the participant which includes reporting it to the Service Coordinator. The Service Coordinator is responsible for timely follow-up in response to the health and safety concerns as outlined in G-1-d.

The Office of Long Term Living is notified about unauthorized use of restraints or seclusion through service providers and participants through the OLTL incident reporting policy.

Also, OLTL provides a statewide toll free Participant Helpline for enrolled participants to register complaints. The participant enrollment form and handbook contain the toll free number. If a complaint is filed regarding the use of a restraint or restrictive intervention, OLTL completes an incident report and follows the established protocol for investigation and remediation as outlined in G-1-d.

- The use of restraints or seclusion 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 or Seclusion.** 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 or 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 restraints or 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-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

**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:

During enrollment and at reevaluation the Service Coordination Agency reviews the process for reporting the use of Restraints and Restrictive Interventions with the participant which includes reporting it to the Service Coordinator. The Service Coordinator is responsible for timely follow-up in response to the health and safety concerns as outlined in G-1-d. The Office of Long-Term Living is notified about unauthorized use of restrictive interventions through service providers and participants through the OLTL incident reporting policy.

Also, OLTL provides a statewide toll free Participant Helpline for enrolled participants to register complaints. The participant enrollment form and handbook contain the toll free number. If a complaint is filed regarding the use of a restraint or restrictive intervention, OLTL completes an incident report and follows the established protocol for investigation and remediation as outlined in G-1-d.

- 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.

- 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:

## 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.

- 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.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**Answers provided in G-3-a indicate you do not need to complete this section**

**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).

**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:

---

(b) Specify the types of medication errors that providers are required to *record*:

---

(c) Specify the types of medication errors that providers must *report* to the State:

---

- 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.

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## 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, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.*

##### i. **Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Number of reportable incidents by type: Abuse, neglect, and exploitation, as well as other reportable incidents.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b>

	Specify:
--	----------

**Performance Measure:**

**Number and percent of waiver participants with more than three reported incidents of abuse, neglect and exploitation in a calendar year.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>

<input type="checkbox"/> <b>Continuously and Ongoing</b>
<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**

**Number and percent of incidents requiring investigations by type: abuse, neglect and exploitation, as well as other reportable incidents.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b>	<input checked="" type="checkbox"/> <b>Annually</b>

Specify:	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**  
**Number and percent of incidents confirmed by type: Abuse, neglect and exploitation, as well as other reportable incidents.**

**Data Source** (Select one):  
**Critical events and incident reports**  
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**  
 Number and percent of incidents of abuse, neglect, and exploitation, as well as other reportable incidents, investigated within required timeframe.

**Data Source** (Select one):  
**Critical events and incident reports**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

**Number and percent of incidents of abuse, neglect, and exploitation, as well as other reportable incidents, for which corrective actions were verified within required timeframe.**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**

Number and percent of Waiver participants who indicate knowledge of how to report abuse, neglect or exploitation.

**Data Source (Select one):**

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**

**Number of complaints by type: Basic service delivery issues**

**Data Source (Select one):**

**Analyzed collected data (including surveys, focus group, interviews, etc)**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> <b>Other</b> 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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**

**Number and percent of complaints investigated regarding basic service issues**

**Data Source (Select one):**

**Analyzed collected data (including surveys, focus group, interviews, etc)**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____

<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**

**Number and percent of complaints addressed within required timeframe regarding basic service issues**

**Data Source (Select one):**

**Analyzed collected data (including surveys, focus group, interviews, etc)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b>

Specify:		Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> 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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 additional information regarding the Quality Management Efficiency Teams (QMETs), please refer to Appendix C.

**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.

When it is discovered that an incident was not acted upon in accordance with waiver standards, OLTL staff that discovered the incident was not reported, immediately direct the Provider to report the incident utilizing OTLT Incident reporting protocols. If immediate action is required to protect the Health and Welfare of the individual the provider is instructed to take such action. Additionally, action should be taken to ensure the incident does not reoccur. When a pattern of not reporting is determined a referral is made to the Quality Management Efficiency Unit (QMEU) for review of the providers incident protocols and implementation. As issues are discovered, Standards Implementation Plans (StIPs) are required.

If it is discovered that a waiver participant does not know how to report a complaint or incident of abuse, neglect or exploitation, BIS contacts the Service Coordinator Supervisor regarding the need to provide appropriate information to the waiver participant. The Service Coordinator Supervisor is responsible to meet

with the consumer, review how to report abuse, neglect or exploitation, and obtain written verification that the participant understands and is knowledgeable on how to report a possible incident or complaint of abuse, neglect or exploitation. The Service Coordinator Supervisor is then responsible for providing the written verification to BIS

If the Office of Quality Management, Metrics and Analytics (QMMA) discovers that a complaint was not acted upon in accordance with waiver standards, QMMA contacts BIS leadership and requests an investigation be conducted as to why the complaint did not meet waiver standards. BIS has 5 business days to report back to QMMA on the root cause as to why the complaint did not meet waiver standards. BIS must also develop a quality improvement plan (QIP) to address the root cause and work with QMMA to ensure the strategy is implemented.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 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 QMS 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## 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.

The Office of Long Term Living (OLTL) includes the Office of Quality Management, Metrics, and Analytics (QMMA) which was created to support the other OLTL Bureaus and programs in maintaining continuous quality improvement. QMMA is composed of :

- \* Quality Management Division
  - Quality Management Unit (QMU)
  - Quality Management Efficiency Unit (QMU)
  - Quality and Compliance Unit (QMU)
- \* Metrics and Analytics Division (M&A)
  - Data Collection and Reporting Section
  - Metrics and Analytics Section

The goals of Quality Management, Metrics & Analytics (QMMA) are:

- \* To conduct quality monitoring of long term living programs and services to ensure compliance with Federal and State regulations
- \* To use data analysis to measure effectiveness of program design and operations,
- \* To recommend strategies for Continuous Quality Improvement
- \* To establish a quality improvement focus within OLTL based on the Six Waiver Assurances:
  - Level of Care
  - Qualified Providers
  - Service Plan
  - Health and Welfare
  - Financial Accountability, and
  - Administrative Authority
- \* To support OLTL management in development and implementation of policies and protocols to achieve desired outcomes
- \* To oversee the development of system wide training for staff, providers and participants
- \* To work effectively with other OLTL Bureaus, internal and external stakeholders, other State Agencies, contracted consultants, the Quality Council, and other individuals or entities regarding Quality Management activities.

The mission of QMMA is to meet these goals in a manner which will bring about maximization of the quality of life, functional independence, health and well being, and satisfaction of participants in OLTL programs and waivers.

QMMA's work consists of quantifying, analyzing, trending, and making initial recommendations regarding priorities and specific quality improvements to OLTL systems, then monitoring system improvement changes for effectiveness.

The process for trending discovery and remediation information (data) begins with QMMA receiving the data from various points in the OLTL system. Database aggregation reports are created for QMMA to trend various aspects of quality including administrative authority, health and welfare, financial accountability, service plan development and implementation, level of care review, and provider qualifications. Additionally, QMMA reviews information from field observations and record reviews to support the information gathered from administrative data.

Provider remediation activities are documented in Standards Implementation Plans (StIPs) which are requested from providers by the QMETs to correct non-compliance issues. Internal remediation activities are documented in Quality Improvement Plans (QIPs) which are requested by the Quality Management Division for internal remediation within a single bureau. The StIPs, QIPs and CAPs are then aggregated for QMMA to review, track trends, and suggest system changes. System changes are considered for the completion of a System Improvement Plan (SIPs) to document and implement system-wide changes.

In order to prioritize the quality management issues, QMMA has assigned each of the six Waiver Assurances to a Quality Management (QM) liaison to review the various quality reports through tracking and trending, and determine possible causes of aberrant data or compliance issues. Quality data is gathered for performance measures from numerous sources, including provider monitoring by the QMETs, etc., and aggregated for tracking and trending. The QM liaison makes initial recommendations and prioritizes issues for problem solving or corrective measures. The QM liaison reviews and responds to aggregated, analyzed discovery and remediation information collected on each of the assurances. In addition to trending and analyzing for each waiver, this structure allows QMMA to trend and analyze across multiple waivers.

QMMA internally reviews the assessments made by the QM liaison. For those issues that are considered critical by the QM liaison, an expedited process of review is implemented. The QMU summarizes the list of priorities and recommendations in a quarterly report to present to the Quarterly Quality Management Meeting (QM2). The QM2 participants consist of appropriate QMMA staff, OLTL Bureau directors (or designee) and internal subject matter experts. The comments from the QM2 are considered and included in a revised report for the Quality Council. The Quality Council is comprised of internal and external stakeholders, whose recommendations are reviewed by the Director of QMMA. The Director makes final recommendations as to

action needed for system improvements to the Deputy Secretary of OLTL. The implemented system improvements return to the quality cycle through monitoring and remediation.

**ii. System Improvement Activities**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of Monitoring and Analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Quality Improvement Committee</b>	<input type="checkbox"/> <b>Annually</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Other</b> 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.

QMMA assists BIS in developing quality management improvement strategies for the needed system design changes. QMMA ensures the strategies are implemented, evaluating the effectiveness of the strategies against tracked and trended data. Additional reports to narrowly track the effect of system changes are developed and produced by Metrics & Analytics, and given to QMU for analysis. The analyses are reviewed in the same manner as other reports through the QM liaison, creating a cycle of continuous quality improvement. Relevant system changes that directly affect stakeholders are broadly communicated to the public via pre-established forums such as OLTL program directives, stakeholder membership groups, listservs, websites, webinars, and direct mailing on a periodic basis.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy (QIS) is evaluated on an on-going and continuous basis through the implementation of the continuous quality cycle. Periodic evaluation also occurs every two years when the QIS is reviewed by the Quarterly Quality Management Meeting and the Quality Council.

The Quality Improvement System outlined also applies to the Aging (control number 0279), Attendant Care (control number 0277), and AIDS (control number 0192) waivers. It is OLTL’s intent to include this Quality Improvement Strategy into the renewal application for the additional waivers under its purview. The discovery and remediation data gathered during the implementation of QIS will be waiver specific and stratified. Because the renewals are staggered, the QIS will automatically receive a periodic evaluation during the point of the renewal.

**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 following are the audit and financial review requirements to ensure the financial integrity of the waiver program.

1. Providers and recipients who are required to have an audit in compliance with the Single Audit Act of 1984, P.L. 98-502 as amended, are also required to complete the Department of Public Welfare's (DPW) annual Single Audit Supplement publication. DPW releases an annual Single Audit Supplement publication to county government and CPA firms. It provides compliance requirements specific to DPW programs, including waiver services. The waiver services are tested in accordance with both the compliance requirements set forth by the OMB Circular A-133 compliance supplement and by the DPW single audit supplement. These procedures are applicable to both public and private organizations providing waiver services that are subject to the Single Audit Act of 1984, P.L. 98-502 as amended.

The Single Audit Act Supplement fulfills four basic needs:

- a. A reference manual detailing additional financial and compliance requirements pertaining to specific DPW program operated by local governments and/or private agencies;
- b. an audit requirement to be referenced when contracting for single audit services, providing the auditing entity with the assurance that the final report package will be acceptable to DPW;
- c. a reporting document for passing compliance requirements to a lower tier agency;
- d. additional guidance to be used in conjunction with Single Audit as amended, OMB Circular A-133, Government Auditing Standards (commonly known as the "Yellow Book") issued by the Comptroller General of the United States; OMB Federal Compliance Supplement, and audit and accounting guidance issued by the AICPA.

2. For those providers which are not required to receive a single audit, DPW may request the provider have the provider's auditor perform an attestation engagement including an audit in accordance with any of the following:

- a. Government Auditing Standards issued by the Comptroller General of the United States or the Generally Accepted Government Auditing Standards.
- b. Standards issued by the Auditing Standards Board.
- c. Standards issued by the American Institute of Certified Public Accountants.
- d. Standards issued by the International Auditing and Assurance Standards Board.
- e. Standards issued by the Public Company Accounting Oversight Board.

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

3. If issues of financial fraud and abuse are suspected, OLTL through the DPW Office of General Counsel (OGC) will refer such issues to the DPW Office of Medical Assistance Programs (OMAP), Bureau of Program Integrity (BPI) for review, investigation, and appropriate action.

4. OLTL staff also conduct ongoing monitoring of financial records that document the need for and the cost of services rendered by providers under the waiver. OLTL reviews PROMISE claims reports against provider's time sheets, paid invoices and other sources provided to verify accuracy of services rendered.

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

- OLTL monitoring and training of provider staff in proper documentation of services rendered
- Time-limited monitoring by Service Coordinator or Service Coordinator Supervisor of weekly time sheets submitted by staff or recipient of service agency
- Suspension of new provider enrollment
- Termination of waiver provider agreement
- Provider refund of inappropriately billed amounts

## 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.*

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be*

specific to this waiver (i.e., data presented must be waiver specific).

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:**

**Number and percent of claims coded as specified in the waiver application**

**Data Source** (Select one):

**Analyzed collected data (including surveys, focus group, interviews, etc)**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**  
**Number and percent of providers submitting accurate claims for services authorized by the waiver and being paid for those services**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 Quality Management Efficiency Teams (QMETS) are the State Medicaid Agency’s (OLTL) regional provider monitoring agents. They conduct monitoring reviews every 2 years with every provider of waiver services. The QMETs comprise of one Program Specialist (regional team lead), one Registered Nurse, one Social Worker, and one Fiscal Agent. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET state coordinator, an OLTL employee. Using a standard monitoring tool which outlines the Financial Accountability as listed in the waiver, the QMET verifies each assurance during the review. A random sample of provider employee and consumer financial records are reviewed to ensure compliance with waiver standards. Additionally, QMET conduct remediation activities as outlined in the waiver application.

**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.

If a report reveals a claim that is overpaid in accordance with the rate methodology, OLTL/ Financial Bureau would initiate steps to recoup the overpayment.

If providers submit claims for services not covered by the waiver and are paid for those services with waiver funds, Bureau of Provider Supports initiates steps to recoup inaccurate payment. QMET works with provider to establish a Corrective Action Plan to prevent billing for unauthorized services. The Quality Management Efficiency Teams is the monitoring agent for OLTL. The QMET tracking database collects the information found by the QMETs for data analysis and aggregation purposes. Through this process, if a QMET discovers a claim does not meet correct payment methodology, the provider, with technical assistance of the QMET, develops a Standards Implementation Plan (STIP). The provider needs to demonstrate through the STIP that it can meet the all waiver financial accountability qualifications and resubmit the claim within 30 calendar days of the QMET review. QMET reviews adjusted claim submissions to assure that recoupment was done correctly. The provider has 15 business days to submit a completed STIP to the appropriate regional QMET, and the QMET reviews and approves the STIP within 30 business days of submission. If the STIP is insufficient; the QMET works with the provider to develop an appropriate STIP. If the provider is unable or unwilling to resolve the deficiency in meeting one or more of the waiver provider qualifications, the provider is notified in writing by OLTL of its intention to dis-enroll the provider. The provider has the right to appeal.

- ii. **Remediation Data Aggregation**

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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).

Rates for adult daily living, clustered shared living, community integration, home health services, personal assistance services, prevocational services, residential habilitation, service coordination, respite, structured day habilitation, supported employment, and therapeutic and counseling services are developed through a market-based methodology. Relevant market information is gathered from multiple sources including but not limited to Bureau of Labor Statistics salary information, other state's rate information, similar program information including Medicare and Medicaid fee schedules. This information is used to create base assumptions in the rate model. Provider cost information is collected through a cost survey to validate assumptions for the cost components of the services (i.e. staffing cost, productivity, indirect costs, etc.) The purpose of the provider information is to inform the assumptions built into the rate methodology and not serve as the quantitative basis for the assumptions. The rates are applicable to all providers, with the rates varying by geographic region.

Rates for Financial Management Service were established as follows:

- One-time Per Participant Start-up Fee - using a market-based methodology, the one-time per participant start-up fee was developed based upon information provided by the current F/EAs which pertained to the estimated costs and percentage of time needed to provide new participant orientation, enroll the participant with the F/EA and enroll direct care workers. The average length of time reported to complete all components of these three tasks was multiplied by Total Staff Compensation Costs, which accounts for F/EA staff, Supervisory staff wages, and non-productive time. The current per member per month fee was then added to the best estimate rate.
- One-time Per Participant Transition Fee - using a similar method as above, the one-time per participant transition fee was based upon gathering participant information from the current F/EA via an electronic file transfer; loading the data into the new vendor's IT system; checking to ensure all required information is received and following up to gather missing documentation as necessary; and securing a new IRS Form 2678. This is primarily data-entry work. The estimated length of time needed to complete these tasks was multiplied by the calculated F/EA Staff Hourly Compensation cost.

- Administrative Per Member Per Month Fee - the per member per month fee was established through the competitive procurement process.

The cost survey and rate model have been developed with input from representative stakeholders including consumers, providers, service coordination agencies, provider associations and consumer advocacy organizations. Additionally, prior to the effective date of rates, the rates and the methodology for calculating rates are communicated to the provider in a public notice published in the Pennsylvania Bulletin.

OLTL reimburses the following services: Accessibility Adaptations, Community Transition Services, Durable Medical Equipment and Supplies, Non-Medical Transportation, and Personal Emergency Response System based on the cost charged to the general public for the good or service.

Claims are processed through PROMISE which is administered by the Office of Medical Assistance Programs (OMAP) and the Department's Bureau of Information Systems (BIS). Claims and payments are monitored by OLTL through the use of PROMISE and HCSIS generated reports.

OLTL obtained public comment on the rate determination methods in a variety of formats which include, stakeholder workgroup discussions, draft documents distributed for comment, communications and other 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:

Providers are enrolled as Medical Assistance providers.

Providers are reimbursed retrospectively based on services provided.

Providers submit claims to the Office of Medical Assistance Programs through PROMISE.

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

PROMISE also verifies with HCSIS that the provider(s) and service(s) on the claim are included in the participant's waiver program.

## 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:

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

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

In addition to the above electronic process, fiscal accountability is also achieved through provider agreements with qualified providers/agencies, through the maintenance of appropriate evaluations and reevaluations, and financial records documenting the need for and the cost of services provided under the waiver. OLTL staff also conducts ongoing monitoring of financial records that document the need for and the cost of services provided under the waiver. OLTL reviews HCSIS reports and conducts onsite reviews of services rendered through review of time sheets where applicable, services rendered reports and participant interviews. OLTL reviews HCSIS reports and conducts onsite reviews of services rendered through review of time sheets where applicable, services rendered reports and participant interviews.

- 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: *Complete item I-3-e.*

One of the Financial Management Service providers is a county based Area Agency on Aging.

## 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:

The Office of Long Term Living (OLTL) established an Organized Health Care Delivery System (OHCDS) that includes Service Coordination Agencies. OHCDS enrollment is voluntary and requires member agencies to sign an agreement with OLTL. OLTL conducted a survey of enrolled Service Coordination Agencies to identified interested agencies. Members of the OHCDS are able to subcontract with providers of Accessibility Adaptations, Equipment, Technology and Medical Supplies, Community Transition Services, Personal Emergency Response (PERS), and Non-Medical Transportation services.

Providers are encouraged to enroll as Medical Assistance Providers and bill the state directly. In order to become an OLTL Waiver Provider, applicants complete a PROMISE Provider Enrollment Base Application along with all applicable documentation for the specific service. Enrollment information is obtained on the OLTL website or by contacting the Bureau of Provider Supports. Waiver participants are given a choice of all enrolled and subcontracted providers through the standardized provider choice form. Members of the OHCDs are responsible for ensuring that their subcontractors meet the provider qualifications contained in the Waiver. The QMET monitor member organizations every two years to ensure that their subcontractors meet the qualifications and that reimbursement for the services is at cost.

**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:  
Do not complete this item.

**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.**

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### 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.**

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### 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.

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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### 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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

**Level(s) of Care: Nursing Facility**

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	33699.57	6712.00	40411.57	51827.00	7059.00	58886.00	18474.43
2	37616.41	6913.00	44529.41	53382.00	7271.00	60653.00	16123.59
3	35348.77	7120.00	42468.77	54983.00	7489.00	62472.00	20003.23
4	35057.51	7334.00	42391.51	56633.00	7714.00	64347.00	21955.49
5	35057.51	7554.00	42611.51	58332.00	7945.00	66277.00	23665.49

**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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	6007	6007
Year 2	8000	8000
Year 3	8000	8000
Year 4	8000	8000
Year 5	8000	8000

**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.

Average length of stay is based on history of 372 reports.

**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:

Based on actual history of utilization and establishing a percentage each service is utilized compared to all services. The number of participants is projected from history and average participants entering the waiver and average participants leaving the waiver. The rates are adjusted for cost of living increases for services.

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:

The D' factor is obtained the same way as the D factor. The entire database of waiver participants is available. Each participant's non-waiver MA costs are identified, including the deduction of Medicare Part D drug costs. Payments made to institutions may not include all services that are available to residents through Medicaid.

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:

Based on Nursing Home Rates with a three percent cola increase per year. The rates have increased by an average of three percent over the last two years.

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:

Based on claims history, including the deduction of Medicare drug costs with a three (3) percent increase each year.

## 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
Personal Assistance Services
Respite
Service Coordination
Supported Employment
Home Health
Financial Management Services
Accessibility Adaptations, Equipment, Technology and Medical Supplies
Adult Daily Living
Community Integration
Community Transition Services
Non-Medical Transportation
Personal Emergency Repsonse (PERS)
Therapeutic and Counseling Services

## 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
<b>Education Total:</b>						452312.00
Education	Hour	50	328.00	27.58	452312.00	
<b>Personal Assistance Services Total:</b>						144553655.34
Personal Assistance	15 Min	2165	5269.00	4.71	53728783.35	
Personal Assistance Participant-Directed	15 Min	3127	7067.00	4.11	90824871.99	
Personal Assistance CSLA	15 Min	0	0.00	4.76	0.00	
<b>Respite Total:</b>						7595491.38
Agency	15 Min	414	1294.00	4.71	2523222.36	
Participant- Directed	15 Min	866	1385.00	4.11	4929575.10	
Facility	Per Diem	67	12.00	177.48	142693.92	
<b>Service Coordination Total:</b>						15245481.68
Service Coordination	Hour	4811	104.00	30.47	15245481.68	
<b>Supported Employment Total:</b>						457533.00
Supported Employment	Hour	30	435.00	35.06	457533.00	
<b>Home Health Total:</b>						4580989.50
Nursing RN	15 Min	481	520.00	16.50	4126980.00	
Occupational Therapy	15 Min	49	174.00	17.75	151336.50	
Physical Therapy	15 Min	49	187.00	17.75	162643.25	
Speech Therapy	15 Min	49	161.00	17.75	140029.75	
Nursing LPN	15 Min	0	0.00	10.00	0.00	
Occupational Therapy Assistant	15 Min	0	0.00	13.14	0.00	
Physical Therapy Assistant	15 Min	0	0.00	10.45	0.00	
<b>Financial Management Services Total:</b>						2579775.00
Financial Management Services - Start Up	Month	3127	11.00	75.00	2579775.00	
Financial Management Services	One Time	0	0.00	277.00	0.00	
<b>Accessibility Adaptations, Equipment, Technology</b>						

<b>and Medical Supplies Total:</b>						12060313.88
Adaptation	Purchase	818	2.00	4531.64	7413763.04	
Equipment	Purchase	818	2.00	2840.19	4646550.84	
<b>Adult Daily Living Total:</b>						251657.39
Enhanced Full Day	Day	11	199.00	74.36	162774.04	
Basic Full Day	Day	8	199.00	52.47	83532.24	
Basic Half Day	Half Day	1	199.00	26.89	5351.11	
<b>Community Integration Total:</b>						10519740.00
Community Integration	15 Min	1155	1012.00	9.00	10519740.00	
<b>Community Transition Services Total:</b>						222354.00
Community Transition Services	Purchase	99	1.00	2246.00	222354.00	
<b>Non-Medical Transportation Total:</b>						2308800.00
Non-Medical Transportation	Trip	1924	120.00	10.00	2308800.00	
<b>Personal Emergency Repsonse (PERS) Total:</b>						1377367.20
Personal Emergency Repsonse (PERS)	Month	2790	11.00	44.88	1377367.20	
<b>Therapeutic and Counseling Services Total:</b>						227874.50
Cognitive Rehabilitation Therapy	15 Min	49	262.00	17.75	227874.50	
Counseling	15 Min	0	0.00	11.43	0.00	
Nutrition Counseling	15 Min	0	0.00	13.30	0.00	
Behavior Therapy	15 Min	0	0.00	14.85	0.00	
<b>GRAND TOTAL:</b>						202433344.87
Total Estimated Unduplicated Participants:						6007
Factor D (Divide total by number of participants):						33699.57
Average Length of Stay on the Waiver:						300

## 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

<b>Education Total:</b>						701224.64
Education	Hour	76	328.00	28.13	701224.64	
<b>Personal Assistance Services Total:</b>						217140137.76
Personal Assistance	15 Min	3600	5269.00	4.58	86875272.00	
Personal Assistance Participant-Directed	15 Min	5200	7067.00	3.54	130089336.00	
Personal Assistance CSLA	15 Min	21	1756.00	4.76	175529.76	
<b>Respite Total:</b>						11801392.00
Agency	15 Min	800	1294.00	4.58	4741216.00	
Participant- Directed	15 Min	1440	1385.00	3.54	7060176.00	
Facility	Per Diem	0	0.00	177.48	0.00	
<b>Service Coordination Total:</b>						25858560.00
Service Coordination	Hour	8000	104.00	31.08	25858560.00	
<b>Supported Employment Total:</b>						1479756.90
Supported Employment	Hour	79	435.00	43.06	1479756.90	
<b>Home Health Total:</b>						7974641.82
Nursing RN	15 Min	48	6074.00	15.02	4379111.04	
Occupational Therapy	15 Min	18	192.00	19.32	66769.92	
Physical Therapy	15 Min	18	244.00	18.33	80505.36	
Speech Therapy	15 Min	18	217.00	19.71	76987.26	
Nursing LPN	15 Min	54	6074.00	10.00	3279960.00	
Occupational Therapy Assistant	15 Min	18	192.00	13.14	45411.84	
Physical Therapy Assistant	15 Min	18	244.00	10.45	45896.40	
<b>Financial Management Services Total:</b>						5346979.00
Financial Management Services - Start Up	One Time	1177	1.00	277.00	326029.00	
Financial Management Services	Month	5370	11.00	85.00	5020950.00	
<b>Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:</b>						21532943.66
Adaptation	Purchase	1400	2.00	4531.64	12688592.00	
Equipment	Purchase	1557	2.00	2840.19	8844351.66	
<b>Adult Daily Living Total:</b>						265177.45
Enhanced Full Day	Day	9	199.00	71.74	128486.34	
Basic Full Day	Day				130748.97	

		11	199.00	59.73		
Basic Half Day	Half Day	1	199.00	29.86	5942.14	
<b>Community Integration Total:</b>						2217008.64
Community Integration	15 Min	336	1012.00	6.52	2217008.64	
<b>Community Transition Services Total:</b>						327916.00
Community Transition Services	Purchase	146	1.00	2246.00	327916.00	
<b>Non-Medical Transportation Total:</b>						3895200.00
Non-Medical Transportation	Trip	3246	120.00	10.00	3895200.00	
<b>Personal Emergency Repsonse (PERS) Total:</b>						2306700.00
Personal Emergency Repsonse (PERS)	Month	4660	11.00	45.00	2306700.00	
<b>Therapeutic and Counseling Services Total:</b>						83661.84
Cognitive Rehabilitation Therapy	15 Min	6	262.00	13.64	21442.08	
Counseling	15 Min	6	262.00	11.43	17967.96	
Nutrition Counseling	15 Min	6	262.00	13.30	20907.60	
Behavior Therapy	15 Min	6	262.00	14.85	23344.20	
<b>GRAND TOTAL:</b>					300931299.71	
Total Estimated Unduplicated Participants:					8000	
Factor D (Divide total by number of participants):					37616.41	
Average Length of Stay on the Waiver:					300	

## 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
<b>Education Total:</b>						0.00
Education	Hour	0	328.00	28.69	0.00	
<b>Personal Assistance Services Total:</b>						217140137.76
Personal Assistance	15 Min	3600	5269.00	4.58	86875272.00	
Personal Assistance Participant-Directed	15 Min	5200	7067.00	3.54	130089336.00	

Personal Assistance CSLA	15 Min	21	1756.00	4.76	175529.76	
<b>Respite Total:</b>						11801392.00
Agency	15 Min	800	1294.00	4.58	4741216.00	
Participant- Directed	15 Min	1440	1385.00	3.54	7060176.00	
Facility	Per Diem	0	0.00	177.48	0.00	
<b>Service Coordination Total:</b>						11435520.00
Service Coordination	15 Min	8000	96.00	14.89	11435520.00	
<b>Supported Employment Total:</b>						1479756.90
Supported Employment	Hour	79	435.00	43.06	1479756.90	
<b>Home Health Total:</b>						7974641.82
Nursing RN	15 Min	48	6074.00	15.02	4379111.04	
Occupational Therapy	15 Min	18	192.00	19.32	66769.92	
Physical Therapy	15 Min	18	244.00	18.33	80505.36	
Speech Therapy	15 Min	18	217.00	19.71	76987.26	
Nursing LPN	15 Min	54	6074.00	10.00	3279960.00	
Occupational Therapy Assistant	15 Min	18	192.00	13.14	45411.84	
Physical Therapy Assistant	15 Min	18	244.00	10.45	45896.40	
<b>Financial Management Services Total:</b>						2359810.00
Financial Management Services - Start Up	One Time	280	1.00	277.00	77560.00	
Financial Management Services	Month	5370	5.00	85.00	2282250.00	
<b>Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:</b>						21532943.66
Adaptation	Purchase	1400	2.00	4531.64	12688592.00	
Equipment	Purchase	1557	2.00	2840.19	8844351.66	
<b>Adult Daily Living Total:</b>						265177.45
Enhanced Full Day	Day	9	199.00	71.74	128486.34	
Basic Full Day	Day	11	199.00	59.73	130748.97	
Basic Half Day	Half Day	1	199.00	29.86	5942.14	
<b>Community Integration Total:</b>						2217008.64
Community Integration	15 Min	336	1012.00	6.52	2217008.64	
<b>Community Transition Services Total:</b>						327916.00
Community Transition	Purchase				327916.00	

Services		146	1.00	2246.00		
<b>Non-Medical Transportation Total:</b>						<b>3895200.00</b>
Non-Medical Transportation	Trip	3246	120.00	10.00	<b>3895200.00</b>	
<b>Personal Emergency Repsonse (PERS) Total:</b>						<b>2277000.00</b>
Personal Emergency Repsonse (PERS)	Month	4600	11.00	45.00	<b>2277000.00</b>	
<b>Therapeutic and Counseling Services Total:</b>						<b>83661.84</b>
Cognitive Rehabilitation Therapy	15 Min	6	262.00	13.64	<b>21442.08</b>	
Counseling	15 Min	6	262.00	11.43	<b>17967.96</b>	
Nutrition Counseling	15 Min	6	262.00	13.30	<b>20907.60</b>	
Behavior Therapy	15 Min	6	262.00	14.85	<b>23344.20</b>	
<b>GRAND TOTAL:</b>						<b>282790166.07</b>
Total Estimated Unduplicated Participants:						<b>8000</b>
Factor D (Divide total by number of participants):						<b>35348.77</b>
Average Length of Stay on the Waiver:						<b>300</b>

## 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
<b>Education Total:</b>						<b>0.00</b>
Education	Hour	0	328.00	29.27	<b>0.00</b>	
<b>Personal Assistance Services Total:</b>						<b>217140137.76</b>
Personal Assistance	15 Min	3600	5269.00	4.58	<b>86875272.00</b>	
Personal Assistance Participant-Directed	15 Min	5200	7067.00	3.54	<b>130089336.00</b>	
Personal Assistance CSLA	15 min	21	1756.00	4.76	<b>175529.76</b>	
<b>Respite Total:</b>						<b>11801392.00</b>
Agency	15 Min	800	1294.00	4.58	<b>4741216.00</b>	
Participant- Directed	15 Min	1440	1385.00	3.54	<b>7060176.00</b>	
Facility	Per Diem	0	0.00	177.48	<b>0.00</b>	

<b>Service Coordination Total:</b>						11435520.00
Service Coordination	15 Min	8000	96.00	14.89	11435520.00	
<b>Supported Employment Total:</b>						1479756.90
Supported Employment	Hour	79	435.00	43.06	1479756.90	
<b>Home Health Total:</b>						7974641.82
Nursing RN	15 Min	48	6074.00	15.02	4379111.04	
Occupational Therapy	15 Min	18	192.00	19.32	66769.92	
Physical Therapy	15 Min	18	244.00	18.33	80505.36	
Speech Therapy	15 Min	18	217.00	19.71	76987.26	
Nursing LPN	15 min	54	6074.00	10.00	3279960.00	
Occupational Therapy Assistant	15 min	18	192.00	13.14	45411.84	
Physical Therapy Assistant	15 min	18	244.00	10.45	45896.40	
<b>Financial Management Services Total:</b>						0.00
Financial Management Services - Start Up	One Time	0	0.00	277.00	0.00	
Financial Management Services	Monthly	0	0.00	85.00	0.00	
<b>Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:</b>						21532943.66
Adaptation	Purchase	1400	2.00	4531.64	12688592.00	
Equipment	Purchase	1557	2.00	2840.19	8844351.66	
<b>Adult Daily Living Total:</b>						265177.45
Enhanced Full Day	Day	9	199.00	71.74	128486.34	
Basic Full Day	Day	11	199.00	59.73	130748.97	
Basic Half Day	Half Day	1	199.00	29.86	5942.14	
<b>Community Integration Total:</b>						2217008.64
Community Integration	15 Min	336	1012.00	6.52	2217008.64	
<b>Community Transition Services Total:</b>						327916.00
Community Transition Services	Purchase	146	1.00	2246.00	327916.00	
<b>Non-Medical Transportation Total:</b>						3895200.00
Non-Medical Transportation	Trip	3246	120.00	10.00	3895200.00	
<b>Personal Emergency Repsonse (PERS) Total:</b>						2306700.00
Personal Emergency Repsonse (PERS)	Month	4660	11.00	45.00	2306700.00	
<b>Therapeutic and</b>						

<b>Counseling Services Total:</b>						<b>83661.84</b>
Cognitive Rehabilitation Therapy	15 Min	6	262.00	13.64	<b>21442.08</b>	
Counseling	15 min	6	262.00	11.43	<b>17967.96</b>	
Nutrition Counseling	15 min	6	262.00	13.30	<b>20907.60</b>	
Behavior Therapy	15 min	6	262.00	14.85	<b>23344.20</b>	
<b>GRAND TOTAL:</b>						<b>280460056.07</b>
Total Estimated Unduplicated Participants:						<b>8000</b>
Factor D (Divide total by number of participants):						<b>35057.51</b>
Average Length of Stay on the Waiver:						<b>300</b>

## 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
<b>Education Total:</b>						<b>0.00</b>
Education	Hour	0	328.00	29.85	<b>0.00</b>	
<b>Personal Assistance Services Total:</b>						<b>217140137.76</b>
Personal Assistance	15 Min	3600	5269.00	4.58	<b>86875272.00</b>	
Personal Assistance Participant-Directed	15 Min	5200	7067.00	3.54	<b>130089336.00</b>	
Personal Assistance CSLA	15 Min	21	1756.00	4.76	<b>175529.76</b>	
<b>Respite Total:</b>						<b>11801392.00</b>
Agency	15 Min	800	1294.00	4.58	<b>4741216.00</b>	
Participant- Directed	15 Min	1440	1385.00	3.54	<b>7060176.00</b>	
Facility	Per Diem	0	0.00	177.48	<b>0.00</b>	
<b>Service Coordination Total:</b>						<b>11435520.00</b>
Service Coordination	15 Min	8000	96.00	14.89	<b>11435520.00</b>	
<b>Supported Employment Total:</b>						<b>1479756.90</b>
Supported Employment	Hour	79	435.00	43.06	<b>1479756.90</b>	
<b>Home Health Total:</b>						<b>7974641.82</b>

Nursing RN	15 Min	48	6074.00	15.02	4379111.04	
Occupational Therapy	15 Min	18	192.00	19.32	66769.92	
Physical Therapy	15 Min	18	244.00	18.33	80505.36	
Speech Therapy	15 Min	18	217.00	19.71	76987.26	
Nursing LPN	15 Min	54	6074.00	10.00	3279960.00	
Occupational Therapy Assistant	15 Min	18	192.00	13.14	45411.84	
Physical Therapy Assistant	15 Min	18	244.00	10.45	45896.40	
<b>Financial Management Services Total:</b>						<b>0.00</b>
Financial Management Services - Start Up	One Time	0	0.00	277.00	0.00	
Financial Management Services	Month	0	0.00	85.00	0.00	
<b>Accessibility Adaptations, Equipment, Technology and Medical Supplies Total:</b>						<b>21532943.66</b>
Adaptation	Purchase	1400	2.00	4531.64	12688592.00	
Equipment	Purchase	1557	2.00	2840.19	8844351.66	
<b>Adult Daily Living Total:</b>						<b>265177.45</b>
Enhanced Full Day	Day	9	199.00	71.74	128486.34	
Basic Full Day	Day	11	199.00	59.73	130748.97	
Basic Half Day	Half Day	1	199.00	29.86	5942.14	
<b>Community Integration Total:</b>						<b>2217008.64</b>
Community Integration	15 Min	336	1012.00	6.52	2217008.64	
<b>Community Transition Services Total:</b>						<b>327916.00</b>
Community Transition Services	Purchase	146	1.00	2246.00	327916.00	
<b>Non-Medical Transportation Total:</b>						<b>3895200.00</b>
Non-Medical Transportation	Trip	3246	120.00	10.00	3895200.00	
<b>Personal Emergency Repsonse (PERS) Total:</b>						<b>2306700.00</b>
Personal Emergency Repsonse (PERS)	Month	4660	11.00	45.00	2306700.00	
<b>Therapeutic and Counseling Services Total:</b>						<b>83661.84</b>
Cognitive Rehabilitation Therapy	15 Min	6	262.00	13.64	21442.08	
Counseling	15 Min	6	262.00	11.43	17967.96	
Nutrition Counseling	15 Min	6	262.00	13.30	20907.60	
Behavior Therapy	15 Min	6	262.00	14.85	23344.20	

GRAND TOTAL:	280460056.07
Total Estimated Unduplicated Participants:	8000
Factor D (Divide total by number of participants):	35057.51
Average Length of Stay on the Waiver:	300