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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Attendant Care Waiver

C. Waiver Number: PA.0277
Original Base Waiver Number: PA.0277.

D. Amendment Number: PA.0277.R03.09

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

07/01/12

Approved Effective Date: 07/01/12
Approved Effective Date of Waiver being Amended: 07/01/08

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of this amendment request is:
1) to revise the provider qualifications of Service Coordinators to match the impending HCBS regulations;
2) to change the unit of service for "Service Coordination" from a monthly unit of service to a 15 minute unit of service, and revise the parameters and service limitations of Service Coordination;
3) to clarify the role of an Registered Nurse during the service planning process;
4) to initiate conflict-free case management within the Attendant Care waiver. Currently, Attendant Care Service Coordination entities, who have responsibility for developing and monitoring the participant's service plan, may also provide direct waiver services to the participant - a potential conflict. Service Coordination entities will no longer be able to provide direct waiver services outside of Nursing Home Transition services, Financial Management Services and those services provided through an Organized Health Care Delivery System; and
5) to modify Appendix J to reflect the new rate and unit of service.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A – Waiver Administration and Operation**	
☐ **Appendix B – Participant Access and Eligibility**	
☑ **Appendix C – Participant Services**	C-3
☑ **Appendix D – Participant Centered Service Planning and Delivery**	D-1-b; D-1-d; D-7
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I – Financial Accountability**	
☑ **Appendix J – Cost-Neutrality Demonstration**	J-2-d

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

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

  Specify:
  Add conflict free case management

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Attendant Care 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.0277
Waiver Number: PA.0277.R03.09
Draft ID: PA.10.03.10

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/08
Approved Effective Date of Waiver being Amended: 07/01/08

1. Request Information (2 of 3)

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

- [ ] **Hospital**

  Select applicable level of care

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

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

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

- [x] **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)

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

Select one:

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

  Check the applicable authority or authorities:

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

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

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

    - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
    - [ ] **§1915(b)(2) (central broker)**
    - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The primary purpose of the Attendant Care Waiver, as part of the Attendant Care Program, is to offer individuals ages 18-59 who are mentally alert with physical disabilities and who are Medicaid eligible the choice of Home and Community Based Services to avoid institutionalization. Historically, the Attendant Care Program exists pursuant to the Attendant Care Services Act (Act-1986-150, 62 P.S. § 3051 et seq.), also known as Act 150. Act 150 provides for basic and ancillary services that enable an eligible person to remain in their home and community rather than an institution and to carry out functions of daily living, self-care and mobility. An eligible person as defined under Act 150 is any individual with physical disabilities who is mentally alert and at least 18 years of age but less than 60 who, in addition to requiring attendant care services, experiences any medically determinable physical impairment which can be expected to last for a continuous period of 12 months or may result in death. That person must also be capable of selecting, supervising and, if needed, firing an attendant and be capable of managing their own financial and legal affairs. The services provided through the Attendant Care Waiver assist individuals in performing activities of daily living (ADL) as well as instrumental activities of daily living (IADL) to enable them in leading a more independent lifestyle.

The term “mentally alert” in attendant care programs in Pennsylvania has traditionally been used to distinguish between those persons with physical disabilities and persons with mental retardation or persons with a mental health diagnosis. In addition, mentally alert has been operationally defined as meeting the eligibility criteria for Act 150 (see above).

Pennsylvania is committed to promoting participant choice and participant direction as evidenced by the expansion of budget authority from a 21-county pilot to statewide. The Attendant Care Waiver also 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. In addition Pennsylvania continues to demonstrate, through the Nursing Home Transition (NHT) initiative, a commitment to the successful transition of individuals to the community. The Attendant Care Waiver remains a component of the NHT initiative through the transition of individuals from a nursing facility setting to Attendant Care Waiver services in a community setting.

The Office of Long Term Living,(OLTL) acting as part of the single State Medicaid Agency (SMA), is responsible for ensuring that the Attendant Care Waiver operates in accordance with applicable Federal regulations as well as meeting all 1915 (c) waiver assurances. The SMA maintains oversight of contracted and local/regional entity functions and the development of waiver-related policies and procedures. The State Medicaid Agency (SMA) also ensures that waiver services are provided by qualified enrolled Medicaid providers. The SMA administers Attendant Care Waiver services statewide to all participants who meet programmatic eligibility requirements and are Medicaid eligible. OLTL as part of the SMA approves all administrative functions of the Attendant Care Waiver.

The SMA has written provider agreements with service providers across the Commonwealth who meet all waiver requirements and are enrolled in Medical Assistance. These local Attendant Care Waiver providers are responsible for direct services to participants. Participants access services through a statewide Independent Enrollment Broker that assists individuals with enrollment into the waiver. The local Area Agencies on Aging (AAAs) are delegated the task of performing

level of care assessments as part of the waiver enrollment process. OLTL has direct oversight of the assessment tasks of the local AAAs. The performance of the initial level of care assessments at the local level is accomplished through contracts with fifty-two Area Agencies on Aging (AAAs) covering all sixty-seven counties in the Commonwealth. The Office of Long term Living (OLTL) is part of the SMA that oversees waiver operations within each of the local AAAs.

The Attendant Care waiver is part of Pennsylvania's global Corrective Action Plan that was approved by CMS on September 15, 2011. Action Steps in the work plan pertain to the Attendant Care waiver include: (1) the development and implementation of a statewide rate-setting methodology; (2) provider oversight; (3) the development of a provider handbook; (4) improved incident management reporting; (5) the development of standardized informational materials for participants; and (6) a standardized process for conveying service authorizations are communicated to providers.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)

(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

• A stakeholder workgroup consisting of Attendant Care Waiver participants, advocates, and providers reviewed and gave input on the waiver renewal.
• Information gathering sessions were held via conference call with Attendant Care Waiver participants. A random sample of Attendant Care Waiver participants from across the Commonwealth were invited to participate.
• Feedback and comment was received from the Attendant Care Local Advisory Committees located throughout the commonwealth.
• Listening session were held in each of the six (6) regions of the Commonwealth. The sessions were open to the public to provide information on potential changes to the waiver and receive public comment on the waiver renewal.
• Feedback was collected from the public via a comment page connected to the OLTL website. Email comments were collected and reviewed by OLTL during the Attendant Care Waiver renewal process.
• The Community Living 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 Service Delivery Structure (SDS) workgroup, a subcommittee of the CLAC, worked extensively with OLTL representatives to offer detailed recommendations for changes to the waiver. All of the SDS recommendations were then reviewed and approved by the CLAC for submission to OLTL.
• 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 Stakeholder Planning Team (SPT) also provides ongoing input and feedback on departmental waivers and services. The SPT includes representation from participants, providers, advocates, and other stakeholders across all DPW programs.
• 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)

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

Last Name: Allen

First Name: Leesa

Title: Director, Bureau of Policy, Analysis and Planning

Agency: Office of Medical Assistance Programs, Department of Public Welfare

Address: P.O. Box 2675

Address 2: Health and Welfare Building

City: Harrisburg

State: **Pennsylvania**

Zip: 17105-2675

Phone: (717) 772-6147 **Ext:** ☐ **TTY**

Fax: (717) 772-6366

E-mail: leallen@pa.gov

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: **Pennsylvania**

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: Bonnie Rose

State Medicaid Director or Designee

Submission Date: Jun 8, 2012

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

Last Name: Gordon

First Name: Vincent

Title: Deputy Secretary

Agency: Office of Medical Assistance Programs, Department of Public Welfare

Address: P.O. Box 2675

Address 2: Room 515; Health and Welfare Building

City: Harrisburg

State: **Pennsylvania**

Zip: 17101

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:

Not Applicable

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 Attendant Care 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. In addition, OLTL policy staff meet regularly with OMAP policy staff to review policy decisions, work plan items and proposed waiver amendments or renewals.

   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.:*
     OLTL contracts with the local Area Agencies on Aging to perform Level of Care Assessments. In addition, effective December 1, 2010, OLTL has contracted with a non-governmental non-state entity to perform waiver related enrollment activities for the Attendant Care waiver. Administration and oversight of these contracts falls within OLTL and the Office of Medical Assistance Programs (OMAP).
   - ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

   - ( ) **Not applicable**
   - (●) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

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

  Initial Level of Care Assessment: A component of the Level of Care Assessment is contracted out to 52 local Area Agencies on Aging. 34 of the AAAs are local county-based organizations - non-state public agencies. A physician certifies an individual's 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) and to help determine the most appropriate location of care.

- **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 an agreement with one statewide Independent Enrollment Broker (IEB). The IEB handles waiver enrollments and does not provide any ongoing direct services to the participant.

  Initial Level of Care Assessment - A component of the Level of Care Assessment is contracted out to 52 local Area Agencies on Aging. 18 of the AAAs are non-governmental non-state public agencies. A physician certifies an individual's 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) and to help determine the most appropriate location of care.

  Annual Re-evaluations - the annual re-evaluation function is delegated to the local Supports Coordination agencies, non-governmental, non-state public agencies.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
   The Office of Long Term Living, Bureau of Individual Support and the Office of Quality Management, Metrics and Analytics are responsible for assessing the performance of contracted and local non-state entities.

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 oversees the performance of the enrollment function which has been 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 re-evaluation functions that are delegated to Supports 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.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state

agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/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:
Medicaid review of aggregated performance measure reports, trends, remediation efforts and system improvements generated for improved services to participants.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Assurances data collected through various performance measures
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of local non-state entities that meet provider agreement obligations.

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of recommendations and approvals of quality improvement interventions/initiatives identified and implemented in the Quarterly Quality Management Meeting and Quality Council Meetings

Data Source (Select one):
Meeting minutes
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver policy decisions developed and approved by the Office of Long Term Living prior to implementation.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of new policy implementation monitored and remediation activity reported by non state entities to the Office of Long Term Living.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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) will be the State Medicaid Agency's (OLTL) regional provider monitoring agents. The QMETs will be comprised of one Program Specialist (regional team lead), one Registered Nurse, one Social Worker, and one Fiscal Agent. Five teams will be dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator. During an on-site review, the QMET will verify that the local non-state agency meets each standard listed in the contractual agreement. A monitoring tool will outline the standards established in the contractual agreement and will be utilized by the QMET during the on-site visit. During the provider review, a random sample of employee and consumer records will be reviewed to ensure compliance with waiver standards. Each local non-state agency will be reviewed on a biannual basis, at minimum. Additionally, QMET will conduct remediation activities as outlined in the waiver application.

For information regarding the Office of Quality Management, Metrics and Analytics (QMMA), Quarterly Quality Management meetings, or the Quality Council, 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 onsite monitoring visits identify agencies that are not meeting their

requirements related to participant waiver enrollment, level of care evaluation, review of participant individualized service plans and Quality Assurance and Quality Improvement activities as outlined in the contractual agreement, the agency will receive written notification of outstanding issues with a request for a corrective action plan (CAP). The CAP is due to the QMET within 15 working days. QMMA staff will review and accept/reject the CAP within 10 working days. Monitoring by the QMET will occur to ensure the corrective action plan was completed and successful in resolving the issue in accordance with the timeframes established for corrective action in the CAP. If the CAP was not successful in correcting the identified issue the technical assistance will be provided by the QMMA unit, Bureau of Individual Supports and Bureau of Provider Supports (BPS).

The Medicaid Agency monitors all quality activities through Bureau reports internally, non-state entities reporting and administrative data. As issues are identified the corrective action will be implemented within 15 calendar days and documented by the bureau with a monthly report to the QMU. The QMU will track and trend remediation efforts, develop initial recommendations and present findings at the Quarterly Quality Management Meetings and at the Quarterly Quality Council Meetings to be addressed in the Medicaid Quality Improvement Process. The Director of the Office of Quality Management and Metrics and Analysis (QMMA) will report to the Deputy Secretary of OLTL.

All new policy implementation will require the non-state entities to monitor implementation and report remediation efforts to the Medicaid Agency through the QMU. The QMU will track and trend remediation activities, and recommend actions through the Quarterly Quality Management Meetings and at the Quarterly Quality Council Meetings to be addressed in the Waiver Quality Improvement Process.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

See detailed QMMA work plan with time lines and responsible parties identified.

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
(●) Aged or Disabled, or Both - General					
	☐	Aged			☐
	☑	Disabled (Physical)	18	59	
	☐	Disabled (Other)			
( ) Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
( ) Mental Retardation or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
( ) Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

To receive waiver services, a participant must meet all of the following conditions:

1. To be eligible to enroll in the Attendant Care Waiver the participant must be 18 through 59 years of age.
2. Participant must be a mentally alert individual with a physical disability who meets all of the following requirements:

a. Experiences any medically determinable physical impairment which can be expected to last for a continuous period of not less than 12 months or that may result in death.
b. Is capable of selecting, supervising and, if needed, firing an attendant.
c. Is capable of managing his/her own financial and legal affairs.
d. Because of physical impairment, the participant requires assistance to perform functions of daily living, self-care, and mobility including, but not limited to, those functions included in the definition of Attendant Care Service.
e. Is capable of directing his or her own care.

3. Participant must be a resident of Pennsylvania.
4. The participant must be determined to require a nursing facility (NF) level of care according to the Level of Care assessment method.
5. The participant must have completed an Attendant Care Signature page indicating they wish to receive Attendant Care Services.
6. Participant must be determined by the County Assistance Office of the Department of Public Welfare to meet the financial eligibility requirements to receive Medicaid benefits and services.
7. Participant must have exhausted all other available third-party benefits prior to receiving the Attendant Care Service.

Historically the Attendant Care Program exists pursuant to the Attendant Care Services Act (Act-1986-150, 62 P.S. §

3051 et seq.), also known as Act 150. Act 150 provides for basic and ancillary services that enable an eligible person to remain in their home and community rather than an institution and to carry out functions of daily living, self-care and mobility. An eligible person as defined under Act 150 is any individual with physical disabilities who is mentally alert and at least 18 years of age but less than 60 who, in addition to requiring attendant care services, experiences any medically determinable physical impairment which can be expected to last for a continuous period of 12 months or that may result in death. That person must also be capable of selecting, supervising and, if needed, firing an attendant and be capable of managing their own financial and legal affairs.

The term "mentally alert" in attendant care programs in Pennsylvania has traditionally been used to distinguish between those persons with physical disabilities and persons with mental retardation or persons with a mental health diagnosis. In addition, mentally alert has been operationally defined as meeting the eligibility criteria for Act 150 (see above). The Attendant Care program has been rooted in the Independent Living philosophy and promotes freedom of individual choice.

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:

Participants who are receiving services through the Attendant Care Waiver before turning age 60 may choose either to:

1. continue to remain in the Attendant Care Waiver upon reaching the age of sixty, or
2. transfer their services to the Aging Waiver upon reaching the age of sixty

In order to ensure continuity of services, the participant's Supports Coordinator sends transition planning notices to the participant's local Area Agency on Aging (AAA) during the months that lead up to their turning age sixty. Joint meetings are also held among the participant, the Supports Coordinator and AAA staff during these transition months. The Supports Coordinator and AAA staff explains the choices of remaining in the Attendant Care Waiver, transferring their services to the Aging Waiver, and the participant's choices regarding waiver service providers. The participant then makes an informed decision about the direction of their services based on the discussions held with their Supports Coordinator and AAA staff.

Appendix B: Participant Access and Eligibility

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

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

- ○ **A level higher than 100% of the institutional average.**

Specify the percentage: _____

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- [ ] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [ ] **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- [ ] **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	7042
Year 2	7200
Year 3	8860
Year 4	9700
Year 5	9700

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

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

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Money Follows the Person Re-balancing Demonstration	

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 Re-balancing Demonstration

Purpose *(describe):*

In order to ensure the success of the Money Follows the Person Rebalancing Demonstration, Pennsylvania has reserved capacity within the Attendant Care Waiver to serve participants in the demonstration. MFP participants will have access to all of the services available in the Attendant Care Waiver. Reserved capacity was determined based on the experience in the state's Nursing Home Transition Program.

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	57
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)

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

Select one:

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

Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- ☑ **A special income level equal to:**

Select one:

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

Specify percentage:

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

Specify dollar amount:

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- ☐ **Aged and disabled individuals who have income at:**

Select one:

- ○ **100% of FPL**
- ○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- (●) **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - (●) **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - ( ) **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- ( ) **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the State plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

    - (●) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage: _____
    - ( ) **A dollar amount which is less than 300%.**

Specify dollar amount:

- **A percentage of the Federal poverty level**

  Specify percentage:

- **Other standard included under the State Plan**

  Specify:

- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.

- **The following formula is used to determine the needs allowance:**

  Specify:

- **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable**
- **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

  Specify:

  Specify the amount of the allowance (*select one*):

  - **SSI standard**
  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The following dollar amount:**

    Specify dollar amount: If this amount changes, this item will be revised.

  - **The amount is determined using the following formula:**

    Specify:

iii. Allowance for the family (*select one*):

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: _____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The State does not establish reasonable limits.**
- ( ) **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The State does not establish reasonable limits.**
- ( ) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

- (●) **The provision of waiver services at least monthly**
- ( ) **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 physician certification form indicating the physician's diagnosis and level of care recommendation.

The Attendant Care Waiver Supports Coordinators conduct the annual reevaluations for participants that are already enrolled in the waiver. Supports 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.

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 is 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 an MA-51 form or 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 Attendant Care Waiver services through the statewide Independent Enrolling Agency.

• The IEB assists the participant with obtaining a completed physician certification form from the participant's physician (M.D. or D.O.)

• The physician completes the certification form indicating the physician's diagnosis and level of care recommendation.

• The IEB forwards the physician's certification form 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).

Note: The same level of care tool, the LOCA, is used in all 67 counties for all individuals entering the waiver.

• The IEB 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 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 Supports Coordination agency is responsible for completion of the annual reevaluation of the level of care.

• The Supports Coordinator completes the annual reevaluation by visiting the participant and completing the CMI.

• The CMI, the standardized needs assessment 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 CMI is compared to the information collected in the individual's previous evaluation or reevaluation.

• The Supports 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 and specified in the Level of Care section of the attached work plan.

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:

Supports Coordinators do not complete the initial evaluations. The initial evaluations of level of care are completed by the local Area Agency on Aging (AAA) Assessors. When a participant is found eligible for the waiver and is subsequently enrolled into the waiver, the participant's Supports Coordinator assumes the role of reevaluating the participant's level of care on an annual basis, or more frequently if needed.

Qualifications for Supports Coordinators:

• 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 an attendant care 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 an attendant care 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 an attendant care program participant.

Supports Coordination Supervisors must meet the same standards as Supports Coordinators.

OLTL monitors the consistency and outcomes of LOC reevaluations as referenced in the Quality Improvement section and specified in the Level of Care component of the attached work plan.

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 Supports Coordinator will meet with the participant in their home to reassess the participant's need for waiver services and complete the CMI. One month prior, the Supports 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 Supports Coordination agency

maintains its own tickler system to complete timely reevaluations and maintain consistency in service.

After the reevaluation is completed, the Supports 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)

Supports Coordinators maintain copies of evaluations and reevaluation in participant's file located at the Supports 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 a nursing facility clinical eligible level of care determination, prior to receipt of 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure/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:
The number and percent of waiver participants who received an annual redetermination of eligibility 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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

For each performance measure/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 LOC determinations that were accurately rendered

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.
N/A

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 –The OLTL's Quality Management Section (QMS) will notify the AAA Director when a LOC is not completed prior to the participant receiving waiver services. The AAA will be required to complete the LOC determination within 2 working days of notification if the LOC has not yet been completed at time of discovery. The QMS will verify LOC completion within 4 working days of discovery. In the event that the participant is found ineligible, the AAA will notify the participant that their waiver services will be terminated in 30 days with full appeal rights, and AAAs will work with the participant to identify other resources to meet their needs. The participant will be disenrolled from the waiver and services terminated. OLTL will notify the AAA of the initiation of recoupment procedures. The AAA will submit a Corrective Action Plan (CAP) to the QMS within 30 calendar days. The QMS will review and approve the submitted CAP within 30 calendar days.

If the participant is found eligible, waiver services will continue uninterrupted and OLTL will start recoupment procedures from the AAA for those services the participant received while they were not eligible. The AAA will submit a Corrective Action Plan (CAP) to the QMS within 30 calendar days. The QMS will review and approve the submitted CAP within 30 calendar days.

Subassurance a.i.b. - The QMS will notify the AAA of late redeterminations on a monthly basis and require

completion within 14 calendar days of notification. The QMS will review the next monthly report to verify completion of the late redeterminations. The AAA will be required to submit a CAP to prevent further late redeterminations. If the redetermination results in the participant's ineligibility, the QMS will inform the AAA to initiate the recoupment process.

Subassurance a.i.c. - The QMS will notify the AAA Director when LOCs are inaccurately rendered. The AAA will be required to render an accurate LOC within 3 business days of notification. The QMS will verify that the corrections have been made. The AAA will be required to submit a CAP to address the issue within 30 days. The QMS will review and approve the submitted CAP within 30 calendar days upon receipt of the CAP.

The QMS will notify the AAA Director of identified errors that occur with LOC specific to each AAA or where indicated with specific staff/assessors. Specific areas regarding completion of the LOC instrument and documentation will be addressed by the QMS with the AAA Director and affected AAA staff on a quarterly basis via direct training.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

○ **No**

◉ **Yes**

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

See detailed QMMA work plan with time lines and responsible parties.

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 Attendant Care 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 IEB and ongoing by their Supports Coordinator, of their right to choose between receiving community services in the waiver, NF services, remain in their present program, or choose not to receive services. All eligible participants will execute his/her choice by completing the OLTL Freedom of Choice Form.

The IEB is responsible for ensuring that all individuals who are determined eligible for waiver services are given a list of all enrolled Supports Coordination agencies, and documenting the participant's choice of Supports Coordinator on the OLTL Service Provider Choice Form. In addition, the IEB is responsible for educating participants of their right to choose from any qualified provider, that they are not required to receive upports coordination and direct services from the same provider, their right to self-direct some or all of their direct services, and that they have the right to change providers at any time. The IEB will give each participant information about the Services and Supports Directory - a web-based listing of all qualified and enrolled waiver providers. Notation is made in the participant's record of receipt of the form; completed forms are maintained in the participant's file with the Supports Coordination ageny. OLTL monitors participant receipt of forms as part of its bi-annual review of providers.

The Supports Coordination agency is responsible for ensuring participants are fully informed of their right to choose service providers at the time of development of the initial Individual Service Plan, at each reevaluation, and at any time during the year when a participant requests a change of providers. The Supports Coordination agency is responsible for providing the particpant with the OLTL Service Provider Choice Form, and ensuring that the particpant has reviewed, completed 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 Supports Coordination agency. 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.

Supports Coordinators maintain copies of the OLTL Freedom of Choice and OLTL Service Provider Choice forms in the participant's record located at the Supports Coordination Agency.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Waiver documents are made available in different languages upon request. If a specific language or interpreter is required, the Supports Coordinators are instructed to call the Office of Long-Term Living. Language assistance will be provided without charge. In addition, sign language services must be made available, at no charge, to individuals who are deaf or hard of hearing.

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

Appendix C: Participant Services

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

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

Service Type	Service	
Statutory Service	Personal Assistance Services	
Statutory Service	Service Coordination	
Supports for Participant Direction	FMS	
Supports for Participant Direction	Participant-Directed Community Supports	
Supports for Participant Direction	Participant-Directed Goods and Services	
Other Service	Community Transition Services	
Other Service	Personal Emergency Response System (PERS)	

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

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 the individual 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);
• 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 enabling adequate nutrition, exercise, keeping of medical appointments and all other health regimens related to healthy living activities;
• 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.

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

Personal Assistance Services may be provided to escort participants to community activities or access other services in the community and be billed as Personal Assistance Services. 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 Participant-Directed Community Supports or Participant-Directed Goods and Services.

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

needs assessment and documented in the participant's service plan.

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

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

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **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):*
N/A
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/PA 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):*
N/A
Certificate *(specify):*
N/A
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 record check and child abuse clearances when applicable.
• 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:
Statutory Service
Service:
Case Management
Alternate Service Title (if any):
Service Coordination
Service Definition *(Scope):*
Service Coordination is a service that assists individuals who receive waiver services in gaining access to needed waiver services and other Medicaid State 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-evaluations 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 the participant's assessed need;
o ensuring that services are provided as identified in the participant's approved service plan 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**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	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:
Agency
Provider Type:
Service Coordination Agency
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
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 people with disabilities or individual over the age of 60; 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:
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):
FMS
Service Definition *(Scope):*
Financial Management Services (FMS) provides financial, payroll, bill-payer services, orientation, and skills

training and related functions for participants under the participant-directed models of service. These services assure that Medicaid funds used to provide services and supports outlined in the participant's Individual Support Plan are managed and paid appropriately as authorized and facilitate the employment of support workers by participants. The FMS provider must operate as either:
1. a Vendor Fiscal/Employer Agent in accordance with Section 3504 of the IRS code and Revenue Procedure 70-6 and Proposed Notice 2003-70, or
2. as a Government Fiscal/Employer Agent in accordance with Section 3504 of the IRS code and Revenue Procedure 80-4 and Proposed Notice 2003-70.
Under the Fiscal/Employer Agent model, the participant is the common law employer of the support providers he/she hires directly. The F/EA will obtain an Employer Identification Number (EIN) from the IRS to operate on behalf of the participant to withhold report and pay state and federal income and unemployment taxes, broker workers compensation for participants' employees and ensure that all federal and state tax laws and labor law requirements are met.
When the F/EA is a direct service provider and/or supports coordination provider, F/EA activities must be separate and distinct from the service delivery functions of the organization. OLTL recognizes that there may be a potential conflict of interest when the F/EA that provided FMS is also providing other waiver services to the participant. OLTL provides and promotes a toll free complaint line for participants to report concerns about their provider including perceived conflicts of interest. Additional safeguards will be developed by OLTL as part of the Qualified Providers section of the work plan to ensure participants have the right and ability to select the provider of their choice. Please see the attached work plan.

Specifically, the FMS entity will complete the following:
• Enroll participants in FMS and apply for and receive approval from the IRS to act as an agent on behalf of the participant.
• Provide orientation and training to participants on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; effective management of workplace injuries; workers compensation; effective management and supervision practices
• Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards
• Conduct criminal background checks and when applicable, child abuse clearances, 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
• Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations
• Broker workers' compensation for all support workers through an appropriate agency;
• Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws
• Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually.
• Assist in implementing the state's quality management strategy related to FMS
• Establish an accessible customer service system for the participant and the Supports Coordinator
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Participants are assessed for services, frequency and duration based upon needs identified and documented in their 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**
- [x] **Provider managed**

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

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	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: FMS

Provider Category:

Agency

Provider Type:

Vendor Fiscal/Employer Agent

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

FMS must be delivered by Fiscal/Employer Agents that are established and legally recognized in the United States, qualified/registered to do business in the Commonwealth of Pennsylvania, enrolled as a Medicaid provider and certified by the Department. F/EAs must meet certification standards that demonstrate they have the capacity to perform the required responsibilities by undergoing and passing an annual certification and review conducted by the OLTL/ Quality Management Unit. These certification and review standards will be developed as part of the Quality Improvement component of work plan. Please see the attached work plan.

The organization providing FMS must apply for and receive approval from the IRS to provide Vendor Fiscal/Employer Agent services in accordance with Section 3504 of the IRS Code and Revenue Procedure 70-6 and Proposed Notice 2003-70, or to provide Government Fiscal/Employer Agent services in accordance with Section 3504 of the IRS Code and Revenue Procedure 80-4 and Proposed Notice 2003-70, and meet requirements and fulfill functions as established by the Code.

In addition, Fiscal/Employer Agents are expected to satisfy the following performance standards and expectations:

• Develop a system to receive and disperse Medicaid funds;
• Utilize an accounting and information system that operates effectively to track and report the expenditures;
• Develop and implement an effective payroll system that addresses all related tax obligations;
• Provide alternative formats to consumers as requested;
• Develop a system to adequately handle grievances and complaints;
• Develop and maintain a system to collect and process all employment related records and documents for consumer-employed providers;
• Establish a customer service mechanism that ensures appropriate consumer access to that entity;
• Have an Information Technology Disaster Recovery Plan for restoring software and master files for backup if needed;
• Develop internal controls to assure project integrity;
• Develop a process for refunding over-collected FICA when applicable;
• Verify wages to assure that consumer-employed providers are paid hourly rates in accordance with the federal and state Department of Labor Fair Labor Standards Act (FLSA);
• Regularly file an accounting audit to ensure system accuracy and compliance with general accounting practices.

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: FMS

Provider Category:
Agency
Provider Type:
Government Fiscal/Employer Agent
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
FMS must be delivered by Fiscal/Employer Agents that are established and legally recognized in the United States, qualified/registered to do business in the Commonwealth of Pennsylvania, enrolled as a Medicaid provider and certified by the Department. F/EAs must meet certification standards that demonstrate they have the capacity to perform the required responsibilities by undergoing and passing an annual certification and review conducted by the OLTL/ Quality Management Unit. These certification and review standards will be developed as part of the Quality Improvement component of work plan. Please see the attached work plan.
The organization providing FMS must apply for and receive approval from the IRS to provide Vendor Fiscal/Employer Agent services in accordance with Section 3504 of the IRS Code and Revenue Procedure 70-6 and Proposed Notice 2003-70, or to provide Government Fiscal/Employer Agent services in accordance with Section 3504 of the IRS Code and Revenue Procedure 80-4 and Proposed Notice 2003-70, and meet requirements and fulfill functions as established by the Code.
In addition, Fiscal/Employer Agents are expected to satisfy the following performance standards and expectations:
• Develop a system to receive and disperse Medicaid funds;
• Utilize an accounting and information system that operates effectively to track and report the expenditures;
• Develop and implement an effective payroll system that addresses all related tax obligations;
• Provide alternative formats to consumers as requested;
• Develop a system to adequately handle grievances and complaints;
• Develop and maintain a system to collect and process all employment related records and documents for consumer-employed providers;
• Establish a customer service mechanism that ensures appropriate consumer access to that entity;
• Have an Information Technology Disaster Recovery Plan for restoring software and master files for backup if needed;
• Develop internal controls to assure project integrity;
• Develop a process for refunding over-collected FICA when applicable;
• Verify wages to assure that consumer-employed providers are paid hourly rates in accordance with the federal and state Department of Labor Fair Labor Standards Act (FLSA);
• Regularly file an accounting audit to ensure system accuracy and compliance with general accounting practices.
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:

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:

Other Supports for Participant Direction

Alternate Service Title (if any):

Participant-Directed Community Supports

Service Definition *(Scope):*

Participant-Directed Community Supports will be offered to participants choosing budget authority under the Services My Way model. The participant is the common law employer of the individual worker(s) providing services; workers are recruited, selected, hired and managed by the participant.

Services include assisting the participant with the following:

• Basic living skills such as eating, drinking, toileting, personal hygiene, dressing, transferring and other activities of daily living;
• Health maintenance activities such as bowel and bladder routines, assistance with medication, ostomy care, catheter care, wound care and range of motion activities;
• Improving and maintaining mobility and physical functioning;
• Maintaining health and personal safety;
• Carrying out household chores such as shopping, laundry, cleaning and seasonal chores;
• Preparation of meals and snacks;
• Accessing and using transportation (If providing transportation, the support worker must have a valid driver's license and liability coverage as verified by the F/EA);
• Participating in community experiences and activities;

Supports will be available to assist the participant in performing employer-related duties and responsibilities through the Fiscal/Employer Agent (F/EA) and Supports Coordinator.

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

Participant-Directed Community Supports cannot be billed at the same time as Personal Assistance Services or services covered by the State Plan, Medicare, other third-parties, including education, home-based schooling and vocational services.

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

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

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Participant-Directed Community Supports

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
• Be 18 years of age or older;

• Have the required skills to perform the services as specified in the participant's Spending Plan;

• Possess a valid Social Security number;

•
When required by the participant, the individual must be able to demonstrate the capability to perform health maintenance activities or receive necessary training
Verification of Provider Qualifications
Entity Responsible for Verification:
The participant and Fiscal/Employer Agent
Frequency of Verification:
• At time of selection of the individual worker to be hired;
• F/EA will verify provider qualifications are met during the provider employment process and will enter into a provider agreement with each provider on behalf of the State Medicaid agency

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:
Other Supports for Participant Direction
Alternate Service Title (if any):
Participant-Directed Goods and Services
Service Definition *(Scope):*
This service is only available through the Services My Way (budget authority) participant-directed model.

Participant-Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan. These items must address an identified need in the participant's traditional service plan (including improving and maintaining the individual's opportunities for full participation in the community) and meet the following requirements. The item or service would meet one or more of the following:
• Decrease the need for other Medicaid services;
• Promote or maintain inclusion in the community;
• Promote the independence of the participant;
• Increase the individual's health and safety in the home environment,
• Develop or maintain personal, social, physical or work-related skills;

• Increase the ability of unpaid family members and friends to receive training and education needed to provide support; or
• Fulfill a medical, social or functional need as identified in the participant's individual service plan.

Participant-directed goods and services are purchased from the participant's Individual Spending Plan. The participant does not have the funds to purchase the item or service or the item or service is not available through another source. As a Medicaid funded service, this definition will not cover experimental goods and services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Participant-Directed Goods and Services cannot be billed at the same time as Personal Assistance Services or services covered by the State Plan, Medicare, other third-parties, including education, home-based schooling and vocational services.

Participant-Direct Goods and Services does not include personal items and services not related to the disability, groceries, rent or mortgage payments, entertainment activities, or utility payments.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Participant-Directed Goods and Services

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Providers must meet applicable state and local regulations and/or Medicaid provider qualifications for the type of service the provider/supplier is providing as written in the participant's Spending Plan.

Providers must meet the acceptable industry standards for the goods or services they provide.

Individuals must:

• Be 18 years of age or older;

•

• Possess a valid Social Security number;

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal/Employer Agent

Frequency of Verification:

• At time of enrollment and as necessary

• The F/EA will verify provider qualifications are met and will enter into a Medicaid provider agreement with each provider on behalf of the State Medicaid Agency

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Participant-Directed Goods and Services

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must meet applicable state and local regulations and/or Medicaid provider qualifications for the type of service the provider/supplier is providing as written in the participant's Spending Plan.

Providers must meet the acceptable industry standards for the goods or services they provide.

Agencies must have:

• Enter into a Medicaid provider agreement with each provider on behalf of the State Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal/Employer Agent

Frequency of Verification:

• At time of enrollment and as necessary

• The F/EA will verify provider qualifications are met

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:

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 – e.g. 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.
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 OLTL.

Expenditures may not include ongoing payment for rent.

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

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

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transition Service Providers

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:
Transition Service Providers
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Transition Service Providers must have:
• sufficient professional staff to perform the needed assessments, coordination and support activities
• registered nurse (RN) consulting services available, either by a staffing arrangement or through a contracted consulting arrangement

Transition Coordinators must:
• 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 one 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 transition coordinator will be required to have 40 hours of training during the first year of employment and 20 hours annually.
• Must pass criminal records check and child abuse clearances

Transition Coordinator Supervisors must meet the same qualifications as a Transition Coordinator including two years of case management experience.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCDS
OLTL

Frequency of Verification:
OHCDS - at time of service
OLTL - 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:
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 Response System (PERS)

Service Definition *(Scope):*
PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "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. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. Installation, maintenance and monitoring are included in this service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Installation is covered one time per residential site.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendors of Personal Emergency Response Systems
Agency	Durable Medical Equipment and Supply Company

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:
Vendors of Personal Emergency Response Systems
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
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 Response System (PERS)

Provider Category:

Agency

Provider Type:
Durable Medical Equipment and Supply Company
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
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: 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 conducted and 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.

OLTL reviews provider personnel records as part of the annual monitoring to ensure that child abuse clearances are conducted and documented.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

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 Attendant Care Waiver will not pay for services furnished to a minor by the child's parent or step-parent.

• The Attendant Care Waiver will not pay for services furnished by a legal guardian.

• The Attendant Care Waiver will not pay for services furnished by a Power of Attorney (POA) for a beneficiary.

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.

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 new waiver provider applications, by provider type, for which provider obtained appropriate licensure/certification in accordance with state law prior to service provision.

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers, by provider type, continuing to meet applicable licensure/ certification following initial enrollment.

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. ***Sub-Assurance: The State 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 of non-licensed/ non-certified provider applicants, by provider type, who met waiver provider qualifications prior to service provision.

Data Source (Select one):
Record reviews, off-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

☐ **Other** Specify:

Data Aggregation and Analysis:

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

Performance Measure:
Number of non-licensed/ non-certified provider applicants, by provider type, who continue to meet waiver qualifications.

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/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, by provider type, meeting provider training requirements.

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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) will be the State Medicaid Agency's (OLTL) regional provider monitoring agents. The QMETs will be comprised of one Program Specialist (regional team lead), one Registered Nurse, one Social Worker, and one Fiscal Agent. Five teams will be 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 will verify that the provider continues to meet each requirement during the on-site review. During the provider review, a random sample of employee and consumer records will be reviewed to ensure compliance with waiver standards. Each provider will be reviewed on a biannual basis, at minimum. Additionally, QMET will 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.
Subassurance a.i.a- Before a provider is enrolled as a qualified waiver provider; it must provide written documentation to the Office of Long Term Living (OLTL) of all state licensing and certification requirements, as well as any other waiver requirements. When OLTL discovers a new or existing provider is enrolled as a

waiver provider, but does has not obtained appropriate certification or licensure, OLTL will send a letter to the provider informing it of the need for the licensure or certification, and a Corrective Action Plan (CAP) for the provider to complete. The letter will also warn that it has no more than 30 calendar days to obtain appropriate licensure or certification before OLTL will begin to disenroll the provider as a qualified waiver provider. The CAP must concisely state how and when the provider will obtain the needed licensure or certification. The provider has 5 business days to submit its CAP to OLTL. OLTL will review and approve the CAP within 5 business days of submission. In the case the CAP is insufficient; OLTL will work with the provider to develop an appropriate CAP. In the case of a staff member not meeting necessary state licensing or certification standards, the staff member cannot provide service to waiver participants until the providers verify staff compliance with state licensing and/or certification requirements. If the provider is unable or unwilling to obtain the appropriate license or certificate the provider will be notified in writing by OLTL of its intention to disenroll the provider. The provider will have the right to appeal.

Subassurance a.i.b- Upon application, OLTL will review verification submitted by the provider to verify it meets the qualification as established in the waiver. If a provider does not meet one or more of the waiver qualifications, OLTL will provide technical assistance to the provider to assist it in building necessary systems to meet the qualification(s). If a provider is unable to meet qualifications even after technical assistance is provided, the application to provide waiver services will be denied. Within two years of becoming a waiver provider (and every two years thereafter), OLTL will conduct an on-site visit of a provider to ascertain whether they continue to meet the provider qualifications outlined in the waiver. The Quality Management Efficiency Teams will be the monitoring agent for OLTL. The QMET monitoring tool will outline each qualification a provider must meet. The qualifications will be categorized according to provider type. The QMET tracking database will collect the information found by the QMETs 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, will develop a Corrective Action Plan (CAP). The provider will need to demonstrate through the CAP that it can meet the all waiver provider qualifications within 30 calendar days of the QMET review. The provider will have 5 business days to submit a completed CAP to the appropriate regional QMET, and the QMET will review and approve the CAP within 5 business days of submission. In the case the CAP is insufficient; the QMET will work with the provider to develop an appropriate CAP. If the provider is unable or unwilling to resolve the deficiency in meeting one or more of the waiver provider qualifications, the provider will be notified in writing by OLTL of its intention to disenroll the provider. The provider will have the right to appeal.

Subassurance a.i.c- The QMET monitoring tool will ascertain if the provider has completed training in accordance with waiver requirements. OLTL will directly supervise 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. In the case a QMET does not verify the provider is training, OLTL will be made aware through the QMET tracking database. The QMET state coordinator will require the appropriate QMET team member to review provider records to assure the training was completed. If a provider has not met training requirements, the provider will be required to submit a CAP. The provider will need to demonstrate through the CAP that it can fulfill all the training requirements within 30 days of the QMET review. The provider will have 5 business days to submit a completed CAP to the appropriate regional QMET, and the QMET will review and approve the CAP within 5 business days of submission. In the case the CAP is insufficient; the QMET will work with the provider to develop an appropriate CAP. The QMET will verify the CAP is in place according to the timeframe as written in policy and the CAP. If the provider is unable or unwilling to resolve the deficiency in meeting one or more of the waiver provider qualifications, the provider will be notified in writing by OLTL of its intention to disenroll the provider. The provider will have the right to appeal.

ii. Remediation Data Aggregation

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

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

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

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.
See detailed QMMA work plan with time lines.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services

authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Service Plan (ISP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker.**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

○ **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

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 Supports 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 Supports 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 Supports 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

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 to meet the participant's identified needs. 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 of the participant's needs or more frequently if there is a change in the participant's needs. 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 whether the participant meets the Nursing Facility level of care. In addition a physician completes a prescription indicating the physician's level of care recommendation.
At the time of enrollment, the independent enrollment broker completes a standardized needs assessment. The standardized assessment 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 level of care assessment and the standardized needs assessment to develop the participant's Individual Service Plan.

The Service Coordinator also reviews and updates the standardized needs assessment annually or on an as needed basis to determine if the ISP requires any changes. If there are changes in the participant's needs, the Service Coordinator must revise the ISP and have the participant sign the signature page of the ISP.

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 Attendant Care Waiver. The Service Coordinator describes and explains the concept of participant-centered service planning, as well as the types of services available through the Attendant Care 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 to maintain health, safety and welfare, 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 ISP. 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 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 for developing ISPs and updating annually by performing the following roles in accordance with specific requirements and timeframes, as established by OLTL:
• Completing 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 remediation activities
• 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 HCSIS. A registered nurse is either on staff with the Service Coordination agency or is available under contract as a nursing consultant to the Service Coordination agency. 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, non-compliant 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 or non-governmental 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, safety 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. OLTL reviews service plans to ensure that non-waiver resources, including MA covered services, are documented on the participant's ISP.

The assignment of responsibility to monitor and oversee the implementation of the service plan:
Upon authorization of the ISP, the Service Coordination agency 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 rendered by the provider. 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, safety 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 to assure provision of services and health and welfare of the participant.

Service coordinators are responsible for documenting and monitoring 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 authorized services 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 or the delivery of services. 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

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 Supports 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 Supports Coordinator, participant and any other participant chosen individuals 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 Supports Coordinator will also describe any unique circumstances on the service plan. The Supports Coordinator will identify if any of the services available through the waiver would be appropriate for the participants' circumstances. The Supports 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 Supports 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 Supports 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 Supports Coordinators to report disruptions of backup plans and strategies.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

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 Supports 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 Supports 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 (including Supports Coordination agencies) 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 Supports 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 Supports 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 supports 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). Supports Coordination providers are required to confirm in HCSIS that the standard OLTL Service Provider Form has been completed whenever the Supports Coordination provider submits a plan creation or plan revision to OLTL where the Supports Coordination provider is also listed as the provider for other services on the plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which

the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

OLTL reviews and approves all initial ISPs. The Supports 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 Supports Coordinator submits that potential change to OLTL through the 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 enrollment broker educates participants that they have the right to choose the providers of the services they will receive, including Supports Coordination agencies, and their right to choose a different provider for different services.

The Supports 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 supports coordinator asks about and documents the effectiveness of the participant's back-up plan during 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 HCSIS. The Supports Coordinator receives an alert of approval or disapproval from OLTL in HCSIS once the ISP is reviewed by OLTL staff. The Supports 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 Supports Coordination Agency for remediation. The Supports Coordinator will be notified through communication from BIS in the comments section of HCSIS. The Bureau of Individual Support will expect the Supports 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 Quality Management, Metrics and Analytics 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:*

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 (ISP's) that are adequate and appropriate to their needs, capabilities, and desired outcomes, 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The State monitors 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 policy regarding who develops the plan, who participates in the process and the timing of the plan development.

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other**	☐ **Annually**	☐ **Stratified**

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

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of Individual Service Plans and related service plan activities that comply how waiver services and other services are coordinated.

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
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, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants whose Individual Service Plan (ISP) included an assessment including risk factors and needs.

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: 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 (ISP's) reviewed and revised before the Attendant Care Waiver participant's annual review date.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants whose Individual Service Plan was revised as needed, to address changing needs.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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, amount, frequency and specified in the Individual Service Plan.

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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 an appropriately completed and signed freedom of choice form that specifies choice was offered between institutional care and waiver services.

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other**	☐ **Annually**	☐ **Stratified**

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants whose records documented that a list of waiver services and providers was provided to, and discussed with, the waiver participant.

Data Source (Select one):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 in the Quality Improvement Section.

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) will contact the Supervisor of the Care Manager responsible for development of the ISP. The Care Manager and Care Manager Supervisor will be expected to 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) will be alerted. The QMET will pull 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 adequately and appropriately addressing the needs of the waiver participant, the provider must complete a Corrective Action Plan (CAP) within 5 days. The QMET will review and approve the CAP within 10 days of submission. In the event the CAP is insufficient; the QMET will work with the provider to develop an appropriate CAP. The QMET will verify the CAP is in place according to the timeframe as written in policy and the CAP.

If the Intake or Annual Participant Satisfaction Survey responses indicate that a waiver participant has unmet needs, BIS will investigate if deficiencies exist in the ISP. If a deficiency is present, the remediation plan listed in the previous paragraph will be initiated.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

See detailed QMMA work plan with time lines and responsible parties identified.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

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); 2) select and manage staff that performs personal assistance services (employer authority); or 3) manage an individual budget (budget authority). 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. Participants choosing Employer Authority or Budget Authority functions as the common law employer of the workers who provide their personal assistance services. Participants are responsible to hire, train, supervise, schedule, and when necessary, fire 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 may utilize a combination of any model(s) to personalize their individual service plan. The ISP is developed in conjunction with the Supports Coordinator to ensure that the participant’s service needs are met, and reflects the participant’s preference for the level of choice and control they have over their services. Supports Coordinators shall offer all participants who have chosen to self-direct their services provider-managed services until the individuals’ support workers are hired. Participants may elect to change their service model at any time by notifying their supports coordinator. Participants may also change their services model by calling the state toll free number and staff from OLTL will assist in the process.

Entities That Support Individuals:

Individuals choosing Employer Authority will receive support from certified Fiscal/Employer Agents and Supports 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 approval from the IRS to act as an agent on behalf of the participant
Provide orientation and training to participants on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; effective management of workplace injuries; workers compensation; effective management and supervision practices
Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards
Conduct criminal background checks and when applicable, child abuse clearances, 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 Support Plan
- Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations
- Broker workers' compensation for all support workers through the an appropriate agency;
- Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws
- Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually
- Assist in implementing the state's quality management strategy related to FMS
- Establish an accessible customer service system for the participant and the Supports Coordinator

In addition, individuals choosing the Employer Authority will receive assistance from Supports 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 Supports 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.

Services My Way Opportunity:
The Commonwealth has expanded Services My Way (budget authority) statewide from a 21 county pilot. Services My Way will provides participants with greater flexibility, choice and control over their services. Under this model, participants have the opportunity to: 1) select and manage staff that perform personal assistance type services under the Participant-Directed Community Supports service definition; 2) manage a flexible Spending plan; and 3) purchase allowable goods and services through their Spending plan. Under Services My Way, the participant/representative is the common-law employer of the service and support workers he/she directly hires.

Entities That Support Individuals
Participants will receive a full-range of supports, ensuring that they are successful with the participant-directed experience. Individuals choosing the Services My Way model will receive support from certified Fiscal/Employer Agents (F/EA) and Support Coordinators to assist them in their role as the common-law employer of their workers. The F/EA will:
1. complete all necessary payroll and employment forms
2. withhold, file and pay payroll and employment taxes
3. process and disburse payroll
4. broker and process payment for workers compensation on behalf of the participant
5. manage the Spending plan
6. certify and enroll individual providers
7. provide training to participant on recruiting, interviewing, hiring, training, managing, and/or dismissing workers

8. monitor spending of the Spending plan

In addition, participants will receive assistance from supports coordinators to develop the Spending plan. OLTL delegated authority to Care managers to approve each participant's Spending plan based on: the individual's level of care assessment, the individual service plan, budget development and the spending plan developed by the participant. Once the Spending plan 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 Spending plan, the supports coordinator will:
1. Advise, train, and support the participant as needed and necessary
2. assist with the execution and development of the Spending plan
3. assist the participant to develop an emergency back-up plan
4. identify risks or potential risks and develop a plan to manage those risks
5. monitor spending of the Spending plan
6. monitor the participant's health and welfare

Services My Way gives choice to waiver participants and improves their individual opportunities for full participant in the community by living independently in their homes, while providing for their health and safety at a cost no greater than traditional services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the 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.

When an individual is found to be eligible for Attendant Care Waiver services, the both the Independent Enrollment Broker and selected Service Coordinator informs the participant of the opportunity to self-direct their Personal Assistance Services through either Employer Authority or Budget Authority. The Service Coordinator documents the participant's choice on the ISP. The participant receives information on self-direction, participation in decision-making and independent living philosophy regardless of which service model they choose. Participants are also advised that they may choose to self-direct their services at any time. Information about participant-direction is shared with participants on an annual basis and at any time at the request of the participant.

Both Employer and Budget Authorities provide the participant the right to hire, fire, schedule, and supervise individuals providing their Personal Assistance Services. Participants choosing Services My Way (budget authority) manage an individual spending plan and purchase allowable goods and services. The Financial Management Services (FMS) Fiscal Employer/Agent (F/EA) performs the fiscal agent tasks including related tax filings for participants choosing Employer Authority. The F/EA informs the participant that training will be provided to assist them in these areas. The F/EA also informs the participant of their responsibility in regard to completion of documentation necessary for billing and reporting of services rendered.

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

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:

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	☑	☐
Participant-Directed Goods and Services	☑	☑
Participant-Directed Community Supports	☑	☑

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:
Financial Management Services (FMS)

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:

Qualified Vendor and Government/Fiscal Employer Agents furnish Financial Management Services to participants. Any interested and qualified provider may provide FMS to participants.

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

FMS entities are paid a monthly fee per participant

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

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

- **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 approval from the IRS to act as an agent on behalf of the participant.
• Provide orientation and training to participants on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; effective management of workplace injuries; workers compensation; effective management and supervision practices
• Conduct criminal background checks and when applicable, child abuse clearances, 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
• Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations
• Broker workers' compensation for all support workers through the an appropriate agency;
• Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws
• Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually.
• Assist in implementing the state's quality management strategy related to FMS
• Establish an accessible customer service system for the participant and the Support Coordinator

Supports furnished when the participant exercises budget authority:

- **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 Commonwealth is currently working with a financial management consultant to develop a certification/recertification tool to monitor and assess the performance of FMS entities. As part of the Quality Management Strategy, the Quality Management Efficiency Teams (QMET) will be responsible for the initial certification and annual recertification of FMS entities. As part of their annual review, the QMETs will monitor to ensure participants have the right and ability to select the provider of their choice and self-referring is not present. Oversight of the FMS entities will be developed further as a component of the work plan.

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

Personal Assistance Services	☐
Participant-Directed Goods and Services	☑
FMS	☑
Participant-Directed Community Supports	☑
Community Transition Services	☐
Personal Emergency Response System (PERS)	☐
Service Coordination	☑

☐ **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:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants have the option to transition from the Employer Authority or Budget Authority model to the Agency model at any point during their waiver enrollment. When a participant voluntarily chooses to terminate participant direction, they will contact their Supports Coordinator who will guide them through the process of transition. The Supports Coordinator will ensure 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

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 transfer from the Consumer Employer model to provider managed services.

Involuntary Termination from participant direction may occur after it has been determined that the Services My Way or the Consumer Employer Model has negatively impacted on the participant's health and welfare and receipt of services 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 the Services My Way or Consumer Employer Model would occur only after a team meeting with the participant, the participant's Supports Coordinator, and any family, friends and advocate if requested by the participant and a review of the recommendations by the OLTL.

The Supports Coordinator will assist the participant in the transfer to the traditional model of service and to ensure 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

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		100
Year 2		300
Year 3		300
Year 4		300
Year 5		300

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:

- [x] **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [ ] **Refer staff to agency for hiring (co-employer)**
- [ ] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **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 using the Services My Way or Consumer-Employer model of service 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.

  For individuals employed through the Consumer Employer Model to perform personal assistance services the FMS agency secures the criminal background check.

  The FMS agency used by the Services My Way or Consumer Employer Model receives funds to cover and secure criminal background checks as part of monthly fee for each participant.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**

- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The participant directed budget is developed based on the Individual Service Plan (ISP). The amount of the individual budget is based on the amounts that are authorized in the service plan. The process for ISP development is the same for all participants in the Attendant Care Waiver, regardless of service model. The Supports Coordinator reviews the participant's needs with the participant 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 home and community and to avoid institutionalization.

The ISP is entered into HCSIS and a projected budget is calculated by HCSIS. For the Services My Way Model, the projected budget is shared with the Participant and the participant works with the supports coordinator to determine how the budget can be utilized to best serve their needs while maintaining their health and welfare. An Spending plan is developed that uses the available monies to purchase goods and services in a manner that allows the participant increased control and flexibility in the way their services are delivered. The cost of the monthly F/EA service fee is deducted from the individual budget amount and is not reflected in the participant's Spending plan.

Information about participant-directed services is made available to participants and the general public through the Cash and Counseling Website, a waiver comparison chart, a brochure and other outreach materials.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The supports coordinator notifies the participant of the individual budget amount following the approval of the ISP by the OLTL. In the event that participant needs change, the participant may request an adjustment to their individual budget by contacting their supports coordinator. The supports coordinator will request approval of the revision from OLTL and the participant will be notified of the approval or denial of the request. The participant has the right to the fair hearing and appeals process as outlined in Appendix F.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Participants have flexibility to manage their services and modify their Spending plan without requiring the prior preparation of a revised Service plan. Funds in the participant's Spending plan may be reallocated when the following criteria are met:
1. The change is within a service category that has been selected for self-direction,
2. The change does not change the total dollar allocated for the participant-directed service category, and
3. The change includes only those supports and services authorized in the participant's service plan.
Participants must notify F/EA when they plan to exercise their authority to reallocate funds prior to implementing the changes. Upon making the change the participant must meet with the supports coordinator to document the changes in the Spending plan.

Any changes that do not meet the criteria above require a change to the service plan and the supports coordinator's approval prior to implementation. To initiate a change of this scope, the participant must meet with his/her support coordinator to amend their service plan and Spending plan. The supports coordinator will review and approve the amendment. Once the approval is granted the participant will submit an amended plan to the F/EA.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Monitoring oversight of the Spending plan is the dual responsibility of the supports coordinator and the F/EA. The F/EA will provide written financial reports to the participant, the support coordinator and OLTL on a monthly and quarterly basis, and as requested by the participant, supports coordinator, and OLTL.
The participant is responsible for developing a monthly Spending plan, which will be approved and authorized by the supports coordinator, and will be utilized to track over and under expenditures.
The F/EA will monitor expenditures, flag significant budget variances, and ensure that the purchase of goods and services and submitted timesheets match the participant's Spending plan. The F/EA will not reimburse services not documented or authorized in the Spending plan. The supports coordinator will track under-utilization and over-utilization and contact the participant and OLTL to resolve potential service delivery problems.

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 Support Coordination provider. The process is identified on the Attendant Care Signature Page. The local Attendant Care Enrolling Agency and Supports 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 Attendant Care Enrolling Agency's or Supports 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."

Initially, the local Attendant Care Enrolling Agency must send a written notice to the individual when the individual is found ineligible for services. When a participant is determined to be likely to require a level of care as indicated in the Attendant Care Waiver, the local Attendant Care Enrolling Agency will inform the participant or his or her legal representative of any feasible alternatives under the waiver and given the choice of either institutional or home and community-based services. The local Attendant Care 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 local Attendant Care Enrolling Agency retains copies of written notices at the local level.

Ongoing, the Supports Coordination provider must send a written notice to the individual when services are denied, suspended, reduced, or terminated. The Supports 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 Supports 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 local Attendant Care Enrolling Agencies and Supports Coordination providers. Local Attendant Care Enrolling Agencies and Supports 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)].

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:

The Office of Long Term Living (OLTL) is responsible for the operation of the grievance/complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The OLTL operates a Hotline # 1-800-757-5042. The hotline provides general eligibility requirements and information and referral for OLTL waivers and programs to the general public, potential applicant or participant/participant family.

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 and the use of restrictive interventions and retraints are followed up in accordance with OLTL Policy as outlined in Appendix G-1 and G-2.

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.

Supports Coordination providers inform and notify participants that their right to appeal is a separate process from calling the toll free hotline. Supports 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.

The Office of Long Term Living is involved with the following efforts to assure that critical events or incidents are reported in the Attendant Care waiver.

1. Pennsylvania Act 28, "Neglect of Care Dependent Persons," provides protection for individuals age 18 and older who, due to physical or cognitive disability or impairment, require assistance to meet their needs for food, shelter, clothing, personal care or health care. The Act states that a caretaker who intentionally causes bodily injury to a care-dependent person by failure to provide treatment or services necessary to preserve a care dependent person's health and safety, or who intentionally uses a physical or chemical restraint or isolates that person resulting in bodily injury, may be prosecuted under the Act.

"Care dependent person" is defined as any adult who, due to physical or cognitive disability or impairment, requires assistance to meet their needs for food, shelter, clothing, personal care or health care. Specified violations of the Act may be punished as a felony of the first degree with a term of imprisonment of not more than 20 years.

A caretaker is defined as, among other things, any person who has an obligation to care for a care-dependent person in the care-dependent person's home for monetary consideration. People who must report incidents under the Act include personnel of the Department of Aging (or Area Agencies on Aging), Department of Health, or Department of Public Welfare when they have reasonable cause to believe that a care-dependent person has suffered bodily injury or been restrained in violation of the Act. Reports must be made immediately to the local law enforcement agency or to the Pennsylvania Office of the Attorney General.

Section V.6.4 of the "Attendant Care Program Requirements" manual issued by the Department of Public Welfare in 2002 states that providers must give training on the provisions of Pennsylvania Act 28. A copy of the Act is also included in the manual. This manual outlines overall policies for the Attendant Care waiver and is distributed to all providers in the program. It is divided into seven chapters covering the history, administration, program and financial eligibility, services, participant rights and a glossary of terms.

2. Pennsylvania Act 13 requires an employee or administrator of a facility (including a home health agency) who has reasonable cause to suspect that a recipient is a victim of abuse to immediately report the abuse. For the Attendant Care Waiver, Act 13 applies when the Personal Assistance Worker is an employee of a home health agency.

Within 48 hours of making all oral reports, the employee or administrator shall make a written report (on forms prescribed by PDA as mandated by Act 13) to the AAA. Additionally, within 48 hours of making an oral report for an abuse involving sexual abuse, serious physical injury, serious bodily injury and suspicious death, the employee and an administrator shall make a written report (on forms prescribed by PDA as mandated by Act 13) to appropriate law enforcement officials. The AAA will forward a copy of the written report to the Department of Aging within 48 hours for all reports involving sexual abuse (not including sexual harassment), serious physical injury, serious bodily injury and suspicious death.

A "recipient" is defined as any individual who receives care, services or treatment in or from a facility (regardless of age). The following types of incidents must be reported:

Abuse: The occurrence of one or more of the following acts: (1) the infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish; (2) the willful deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health; (3) sexual harassment; and/or (4) sexual abuse which is intentionally, knowingly or recklessly causing or attempting to cause rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault or incest.

Serious Bodily Injury: An injury which creates a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of the function of a body member or organ.

Serious Physical Injury: An injury that causes a person severe pain or significantly impairs a person's physical functioning, either permanently or temporarily.

Sexual Abuse: Intentionally, knowingly or recklessly causing or attempting to cause rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, indecent assault or incest.

3. Additionally, the Office of Long Term Living maintains a statewide toll free number that has been widely publicized to program participants, attendants, providers, legal representatives and family members. The participant enrollment form, which is required under the program, and a participant handbook, contain the toll free number. This allows participants, attendants, and other individuals (e.g., family members, neighbors, provider employees) to report incidents of abuse, neglect and exploitation of participants in the Attendant Care waiver.

4.The enrolling agency reviews a standardized form with the participant during enrollment and at reevaluation. The process for reporting health and safety concerns is reviewed with the participant which includes reporting it to the Supports Coordinator. The Supports Coordinator is responsible for timely follow-up in response to the health and safety concerns. There are currently no specified time frames in which the Supports Coordinator must respond -- other than those required under Acts 13 and 28.

Further development of critical incident reporting and monitoring, and efforts to provide education are outlined in the Health and Welfare section of the work plan.

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).

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.

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.

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.

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:

The enrolling agency reviews a standardized form with the participant during enrollment and at reevaluation. The process for reporting the use of Restraints and Restrictive Interventions is reviewed with the participant which includes reporting it to the Supports Coordinator. The Supports Coordinator is responsible for timely follow-up in response to the health and safety concerns.

The Office of Long Term Living is notified about unauthorized use or restraints or seclusion through the Supports Coordination providers and participants. OLTL provides a toll free number for agencies and individuals to register a complaint. The participant enrollment form and handbook contain the toll free number. Once a complaint has been filed it is recorded by OLTL staff in a central database and appropriate actions are taken, including notification of the local law enforcement agency. To assist in the detection of the unauthorized use of restraints or seclusion, OLTL requires all Supports Coordination providers to annually provide staff training on detection and prevention of abuse and neglect including the use of restraints.

Further development of reporting and monitoring on use of restraints and education on this topic are outlined in the Health and Welfare section of the work plan.

○ **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:

The enrolling agency reviews a standardized form with the participant during enrollment and at reevaluation. The process for reporting the use of Restraints and Restrictive Interventions is reviewed with the participant which includes reporting it to the Supports Coordinator. The Supports Coordinator is responsible for timely follow-up in response to the health and safety concerns.

The Office of Long Term Living is notified about unauthorized use or restraints or seclusion through the Supports Coordination providers and participants. OLTL provides a toll free number for agencies and individuals to register a complaint. The participant enrollment form and handbook contain the toll free number. Once a complaint has been filed it is recorded by OLTL staff in a central database and appropriate actions are taken, including notification of the local law enforcement agency. To assist in the detection of the use of restrictive interventions, OLTL requires all Supports Coordination providers to annually provide staff

training on detection and prevention of abuse and neglect including the use of restrictive interventions.

Further development of reporting and monitoring on use of restrictive interventions and education on this topic are outlined in the Health and Welfare section of the work plan.

○ **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.

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 reported abuse, neglect and exploitation incidents by type

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Services My Way Participants
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
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):
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Services My Way Participants
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of abuse, neglect and exploitation incidents by type requiring investigation.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Services My Way Participants

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of abuse, neglect and exploitation incidents by type which are substantiated

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Services My Way Participants
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of abuse, neglect and exploitation incidents investigated within required timeframe.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Services My Way Participants
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent abuse, neglect and exploitation incidents for which corrective actions were verified within required timeframe.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Services My Way Participants
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number of providers who fail to report abuse, neglect and exploitation incidents.

Data Source (Select one):
Record reviews, on-site
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):*

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Services My Way Participants
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number of waiver participants who indicate knowledge of how to report abuse, neglect and exploitation.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number of complaints by type: Basic service delivery issues, abuse, neglect or

exploitation.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Services My Way Participants
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of complaints investigated regarding basic service issues, abuse, neglect, or exploitation

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Services My Way Participants
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of complaints addressed within required timeframe regarding basic service issues, abuse, neglect or exploitation

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Services My Way Participants
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
For additional information regarding the Quality Management Efficiency Teams (QMETs), please refer to Appendix C.

For additional information on the Office of Quality Management, Metrics and Analytics (QMMA), please refer to 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.
If it is discovered that an incident was not acted upon in accordance with waiver standards (i.e. failed to meet performance measure), the following remediation strategy will be enacted.

The Bureau of Individual Supports (BIS) will contact the provider regarding the incident. If immediate action is needed to protect the health and welfare of the individual, BIS will instruct the provider to take such action. The provider will be required to provide BIS with a clarification of why the incident did not meet waiver standards and develop a Corrective Action Plan (CAP). The CAP will address the root cause as to why the waiver standard was not met as well as outline a method to prevent the deficiency from occurring in the future. The clarification and CAP will be due to BIS within 5 business days. BIS will have 10 business days to review and approve the CAP. If the provider does not develop a sufficient CAP, BIS will provide technical assistance to improve the CAP. If after 30 days, the provider is unwilling/ unable to develop an acceptable CAP, OLTL will begin the process to dis-enroll the provider. The provider will have the right to appeal. The QMET will be responsible to do an on-site review, if applicable, to ensure that the CAP is being implemented as written and within in the timeframes listed.

If the Office of Quality Management, Metrics and Analytics (QMMA) discovers that a compliant was not acted upon in accordance with waiver standards, the following remediation strategy will be enacted.

QMMA will contact BIS leadership and request an investigation be conducted as to why the compliant did not meet waiver standards. BIS will have 5 business days to report back to QMMA on the root cause as to why the complaint did not meet waiver standards. BIS will also develop a quality improvement strategy to address the root cause and work with QMMA to ensure the strategy is implemented.

If it is discovered that a waiver participant does not know how to report a complaint or incident of abuse, neglect or exploitation, the following remediation strategy will be enacted.

BIS will contact the Supports Coordinator supervisor regarding the need to provide appropriate information to the waiver participant. The Supports 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 Supports Coordinator supervisor is then responsible for providing the written verification to BIS.

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

Responsible Party *(check each that*	**Frequency of data aggregation and**

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

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.
See detailed QMMA work plan with time lines and responsible parties identified.

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.

As part of our reorganization, the OLTL has recently created an Office of Quality Management, Metrics, and Analytics (QMMA) to support other OLTL Bureaus and Programs regarding quality improvement. The QMMA is composed of :
* Quality Management Section
* Quality Management Unit (QMU)
* Quality Management Efficiency Teams
* Quality and Compliance Specialists
* Metrics and Analytics Section (M&A)
* Data Collection and Reporting Unit
* Analytics

The goals of the OLTL Quality Management Unit (QMU) 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 framework within OLTL based on the 7 focus areas of the CMS Quality Framework Focus Areas and desired outcomes:
- Participant Access
- Participant-Centered Service Planning and Delivery
- Provider Capacity and Capabilities

- Participant Safeguards
- Participant Rights and Responsibilities
- Participant Outcomes and Satisfaction
- System Performance

* 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 strategies

The mission of the QMU 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.

The QMMA's work is to quantify, analyze, trend, and make initial recommendations regarding priorities and specific quality improvements to OLTL systems.

The processes for developing trends, priorities and system improvements are currently outlined in the quality management section of the work plan.

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.

In order to prioritize the quality management issues, the QMU has assigned each assurance to a Quality Management (QM) liaison to review the reports provided through tracking and trending and determine possible causes of aberrant data. The QM liaison will make initial recommendations and prioritize issues for problem solving or corrective measures. The QM liaison will review and respond to aggregated, analyzed discovery and remediation information collected on each of the assurances.

The QMMA will internally review the assessments made by the QM liaison. For those issues that are considered critical by the QM liaison, an expedited process of review will be implemented. The QMU summarizes the list of priorities and recommendations in a quarterly report to present to the Quarterly Quality Management Meeting. The Quarterly Quality Management meeting participants consist of appropriate QMMA staff, OLTL Bureau directors (or designee) and internal subject matter experts. The comments from the Quarterly Quality Management meeting will be considered and included in a revised report for the Quality Council. The Quality Council is comprised of internal and external stakeholders whose recommendations will be reviewed by the Director of QMMA. The Director makes final recommendations as to action needed for system improvements to the Deputy Secretary of OLTL.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☐ **Annually**
☐ **Other**	☐ **Other**

Specify:	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.

Once authorization is received to implement the quality improvement recommendations, the QMMA will assist appropriate parties in developing quality management improvement strategies that require system design change. The QMMA will ensure the strategies are implemented and will evaluate the effectiveness of the strategies against data that is tracked and trended. Additional reports to narrowly track the effect of system changes will be developed and produced by Metrics &Analytics and given to QMU for analysis. The analysis will be reviewed in the same manner as other reports created by the QM liaison.

Relevant system changes that directly affect stakeholders will be broadly communicated to the public via pre-established forums such as OLTL program directives, stakeholder membership groups, listservs, websites, 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) will be evaluated on an on-going and continuous basis through the implementation of the work plan. Periodic evaluation will occur every two years when the QIS is reviewed by the Quarterly Quality Management Meeting and the Quality Council.

The Quality Improvement System outlined applies to the Aging (control number 0279) and Attendant Care (control number 0277) 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 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 fical 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 conducts 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 and paid according to the rate methodology as specified in the waiver application.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of provider 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:

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

Data Aggregation and Analysis:

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

	Specify:

Performance Measure:
Number and percent of Services My Way participants who spend 80% or less of their spending plan.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of Services My Way participants who are directed to other service models because of non-authorized use of funds.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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) will be the State Medicaid Agency's (OLTL) regional provider monitoring agents. They will conduct bi-annual monitoring visits 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 will be 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 will verify each assurance during the on-site review. A random sample of provider employee and consumer financial records will be reviewed to ensure compliance with waiver standards. Additionally, QMET will 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 quarterly 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 will initiate steps to recoup inaccurate payment. QMET will work with provider to establish a Corrective Action Plan to prevent billing for unauthorized services. The Quality Management Efficiency Teams will be the monitoring agent for OLTLThe QMET tracking database will collect 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, will develop a Corrective Action Plan (CAP). The provider will need to demonstrate through the CAP that it can meet the all waiver financial accountability qualifications and resubmit the claim within 30 calendar days of the QMET review. QMET will review adjusted claim submissions to assure that recoupment was done correctly. The provider will have 5 business days to submit a completed CAP to the appropriate regional QMET, and the QMET will review and approve the CAP within 5 business days of submission. In the case the CAP is insufficient; the QMET will work with the provider to develop an appropriate CAP. If the provider is unable or unwilling to resolve the deficiency in meeting one or more of the waiver provider qualifications, the provider will be notified in writing by OLTL of its intention to dis-enroll the provider. The provider will have the right to appeal.

From Administrative Data reports provided by the FEAs, under and over usage of SMW spending plans is targeted and reported to OLTL for the performance measures above. BIS regional representatives will contact the SC/CM requesting a review of the spending plan and counseling of the participant as needed. Follow-up reports on actions taken will be returned to OLTL.
QMMA will review service notes and send surveys to SCs to determine reasons for termination from SMW. The survey results will be analyzed so recommendations for system improvement can be made.

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

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

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

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

○ **No**

◉ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
See detailed QMMA work plan with time lines and responsible parties.

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 financial management services, personal assistant services, service coordination, and transition service coordination 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. 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.

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, Participant Directed Community Supports, Participant Directed Goods and Services 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 Attendant Care 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.

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) is working to create an Organized Health Care Delivery System (OHCDS) that would include but not be limited to Area Agencies on Aging and Supports Coordination

Agencies. OHCDS enrollment will be voluntary and require member agencies to sign an agreement with OLTL. Vendors will still have the option of billing Medical Assistance directly if they choose to do so. Personal Emergency Response (PERS) and Community Transition Services (CTS) will be covered under the proposed OHCDS. Policies and procedures related to the implementation of the OHCDS will be developed as part of the work plan.

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*:

- [x] **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:

The State share for the funding of the Attendant Care waiver is appropriated from the State Legislature. The State share includes various amounts of intergovernmental transfer agreements (IGT's). Money is wire transferred to the Commonwealth's general fund account. The Commonwealth uses the money to pay for services and draws funds from the account as needed. The DPW's Budget Office determines the use of the IGT fund. The IGT funding is in the amount of $15,272,000 for Pennsylvania's Attendant Care home and community based services which includes the Attendant Care waiver. The receipt of the IGT funding is facilitated through the IGT methodology. The funding is being phased out and will be replaced with state dollars. DPW is in the sixth year of an eight year phase out plan.

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.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

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

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-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	24856.96	7595.28	32452.24	47011.26	6636.03	53647.29	21195.05
2	25410.30	7823.14	33233.44	49228.62	6835.11	56063.73	22830.29
3	21061.91	8057.83	29119.74	51536.72	7040.16	58576.88	29457.14
4	21074.23	8299.56	29373.79	53939.00	7251.36	61190.36	31816.57
5	20557.51	8548.55	29106.06	56439.03	7468.90	63907.93	34801.87

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	**7042**	7042
Year 2	**7200**	7200
Year 3	**8860**	8860
Year 4	**9700**	9700
Year 5	**9700**	9700

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:

Based on actual history, including the deduction of Medicare drug costs, as reported through claims history. Three (3) percent increase is added each year based on the increase for the G and G' to keep the prime a consistent increase between G and D.

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
Personal Assistance Services
Service Coordination
FMS
Participant-Directed Community Supports
Participant-Directed Goods and Services
Community Transition Services
Personal Emergency Response System (PERS)

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
Personal Assistance Services Total:						**153836752.35**
Personal Assistance Services Agency	15 min	2324	3445.00	4.86	**38910034.80**	
Personal Assistance Services Participant Directed	15 min	5393	5185.00	4.11	**114926717.55**	
Service Coordination Total:						**12906295.92**
Service Coordination	Month	7042	12.00	152.73	**12906295.92**	
FMS Total:						**4943700.00**
FMS	Month	5493	12.00	75.00	**4943700.00**	
Financial Managment Services Start Up	One Time	0	0.00	277.00	**0.00**	
FMS Start-up	One-time	0	0.00	277.00	**0.00**	
Participant-Directed Community Supports Total:						**1783998.00**
Participant-Directed Community Supports	Month	100	9.00	1982.22	**1783998.00**	
Participant-Directed Goods and Services Total:						**764741.00**
Participant-Directed Goods and Services	Purchase	100	1.00	7647.41	**764741.00**	
Community Transition Services Total:						**300000.00**
Community Transition Services	One Time Purchase	100	1.00	3000.00	**300000.00**	
Personal Emergency						

Response System (PERS) Total:						**507200.00**
Personal Emergency Response System (PERS)	Month	1268	10.00	40.00	**507200.00**	
			GRAND TOTAL:			**175042687.27**
			Total Estimated Unduplicated Participants:			**7042**
			Factor D (Divide total by number of participants):			**24856.96**
			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
Personal Assistance Services Total:						**155938430.50**
Personal Assistance Services Agency	15 min	2375	3427.00	4.96	**40370060.00**	
Personal Assistance Services Participant Directed	15 min	5335	5170.00	4.19	**115568370.50**	
Service Coordination Total:						**13459392.00**
Service Coordination	Month	7200	12.00	155.78	**13459392.00**	
FMS Total:						**5153652.00**
FMS	Month	5614	12.00	76.50	**5153652.00**	
Financial Managment Services Start Up	One Time	0	0.00	277.00	**0.00**	
FMS Start-up	One-time	0	0.00	277.00	**0.00**	
Participant-Directed Community Supports Total:						**5351976.00**
Participant-Directed Community Supports	Month	300	12.00	1486.66	**5351976.00**	
Participant-Directed Goods and Services Total:						**2222100.00**
Participant-Directed Goods and Services	Purchase	300	1.00	7407.00	**2222100.00**	
Community Transition Services Total:						**300000.00**
Community Transition Services	One Time Purchase	100	1.00	3000.00	**300000.00**	
Personal Emergency Response System (PERS) Total:						**528360.00**
Personal Emergency						

Response System (PERS)	Month	1295	10.00	40.80	528360.00	
				GRAND TOTAL:		182953910.50
				Total Estimated Unduplicated Participants:		7200
				Factor D (Divide total by number of participants):		25410.30
				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
Personal Assistance Services Total:						158958899.00
Personal Assistance Services Agency	15 min	2375	3427.00	5.06	41183972.50	
Personal Assistance Services Participant Directed	15 min	5335	5170.00	4.27	117774926.50	
Service Coordination Total:						13737600.00
Service Coordination	Month	7200	12.00	159.00	13737600.00	
FMS Total:						5256725.04
FMS	Month	5614	12.00	78.03	5256725.04	
Financial Managment Services Start Up	One Time	0	0.00	277.00	0.00	
FMS Start-up	One-time	0	0.00	277.00	0.00	
Participant-Directed Community Supports Total:						5352012.00
Participant-Directed Community Supports	Month	300	12.00	1486.67	5352012.00	
Participant-Directed Goods and Services Total:						2466300.00
Participant-Directed Goods and Services	Purchase	300	1.00	8221.00	2466300.00	
Community Transition Services Total:						306000.00
Community Transition Services	One Time Purchase	100	1.00	3060.00	306000.00	
Personal Emergency Response System (PERS) Total:						530950.00
Personal Emergency Response System (PERS)	Month	1295	10.00	41.00	530950.00	
				GRAND TOTAL:		186608486.04

Total Estimated Unduplicated Participants:	8860
Factor D (Divide total by number of participants):	21061.91
Average Length of Stay on the Waiver:	300

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
Personal Assistance Services Total:						**170600749.80**
Personal Assistance Services Agency	15 min	1905	3445.00	4.58	**30057280.50**	
Personal Assistance Services Participant Directed	15 min	7657	5185.00	3.54	**140543469.30**	
Service Coordination Total:						**18877752.00**
Service Coordination	Month	9700	12.00	162.18	**18877752.00**	
FMS Total:						**7523273.00**
FMS	Month	7657	11.00	85.00	**7159295.00**	
Financial Managment Services Start Up	One Time	657	1.00	277.00	**181989.00**	
FMS Start-up	One-time	657	1.00	277.00	**181989.00**	
Participant-Directed Community Supports Total:						**5851533.12**
Participant-Directed Community Supports	Month	328	12.00	1486.67	**5851533.12**	
Participant-Directed Goods and Services Total:						**833567.69**
Participant-Directed Goods and Services	Purchase	109	1.00	7647.41	**833567.69**	
Community Transition Services Total:						**140000.00**
Community Transition Services	One Time Purchase	35	1.00	4000.00	**140000.00**	
Personal Emergency Response System (PERS) Total:						**593200.00**
Personal Emergency Response System (PERS)	Month	1483	10.00	40.00	**593200.00**	

GRAND TOTAL:	204420075.61
Total Estimated Unduplicated Participants:	9700
Factor D (Divide total by number of participants):	21074.23

Average Length of Stay on the Waiver:	300

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
Personal Assistance Services Total:						**170600749.80**
Personal Assistance Services Agency	15 min	1905	3445.00	4.58	**30057280.50**	
Personal Assistance Services Participant Directed	15 min	7657	5185.00	3.54	**140543469.30**	
Service Coordination Total:						**13865568.00**
Service Coordination	15 min	9700	96.00	14.89	**13865568.00**	
FMS Total:						**7523273.00**
FMS	Month	7657	11.00	85.00	**7159295.00**	
Financial Managment Services Start Up	One Time	657	1.00	277.00	**181989.00**	
FMS Start-up	One-time	657	1.00	277.00	**181989.00**	
Participant-Directed Community Supports Total:						**5851533.12**
Participant-Directed Community Supports	Month	328	12.00	1486.67	**5851533.12**	
Participant-Directed Goods and Services Total:						**833567.69**
Participant-Directed Goods and Services	Purchase	109	1.00	7647.41	**833567.69**	
Community Transition Services Total:						**140000.00**
Community Transition Services	One Time Purchase	35	1.00	4000.00	**140000.00**	
Personal Emergency Response System (PERS) Total:						**593200.00**
Personal Emergency Response System (PERS)	Month	1483	10.00	40.00	**593200.00**	

GRAND TOTAL:	**199407891.61**
Total Estimated Unduplicated Participants:	**9700**
Factor D (Divide total by number of participants):	**20557.51**
Average Length of Stay on the Waiver:	300