



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE  
DEPARTMENT OF AGING  
**OFFICE OF LONG TERM LIVING**

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December 1, 2008

Dear Colleague:

We are pleased to inform you that the Office of Long Term Living's (OLTL) application to renew the Aging Waiver has been approved by the Centers for Medicare and Medicaid Services (CMS). This renewal contains clearer descriptions of our processes and service definitions, but more importantly, it also allows for the implementation of a groundbreaking new initiative called "TeleCare." The Aging Waiver renewal application has been placed on this web site for your review.

Approval of the waiver application is subject to completion of a detailed work plan that has been negotiated with CMS (an abridged version of the work plan is also available on this web site). Please take special note that the work plan will require significant change in waiver operations over the coming years in order to fulfill federal requirements. This, coupled with recent calls for fiscal restraint, will present real challenges for both state and local governments.

A description of the major changes to the Aging Waiver can be found in the beginning section of the application. One of the most important issues raised by CMS during the approval process involved the commonwealth's administrative oversight of waiver operations. During the coming months, we will be issuing a series of revised policies to clarify OLTL's role in administrative authority. We look forward to working in close cooperation with the Aging network, consumers, caregivers and other stakeholders regarding these changes to ensure effective implementation.

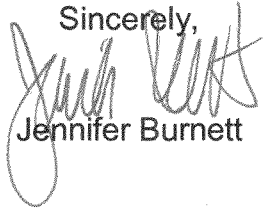
Other planned revisions in the Aging Waiver include:

- Implementation of a comprehensive Quality Management strategy that requires more effective monitoring of local agency operations. Part of this effort will involve the timely development of a stronger incident reporting process;
- Refinement of waiver service definitions and development of a standard statewide rate-setting process, including the addition of case management as an Aging Waiver Service;

- Design of a new, innovative “Services My Way” Pilot (Cash and Counseling model);
- Examination of the process used for Level of Care (LOC) determinations to maximize statewide consistency and appropriateness, and
- Consideration of policies that would allow for Payment to Spouses as Personal Assistance Service Workers.

The Office of Long Term Living looks forward to working with you as we continue our efforts to improve the Aging waiver. For questions or comments, please contact the Office of Policy and Strategic Planning at (717) 705-3705 or email the [PW, OLTLsupports@state.pa.us](mailto:OLTLsupports@state.pa.us). We look forward to working with you on these important initiatives, and thank you for your continued cooperation.

Sincerely,



Jennifer Burnett

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Major Changes

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Describe any significant changes to the approved waiver that are being made in this renewal application:

The Office of Long Term Living (OLTL) was created in October 2007 and acts as part of the State Medicaid Agency responsible for the administration of the Aging Waiver. The Pennsylvania Department of Aging, which formerly administered the Aging Waiver, no longer oversees its operation. The State Medicaid Agency (Office of Long Term Living) was formed to rebalance Pennsylvania's long-term living system and to provide opportunities for older people and people with disabilities to live independently. The State Medicaid Agency is responsible for ensuring that the Aging Waiver operates in accordance with applicable Federal regulations and the provisions of the waiver program.

The State Medicaid Agency is committed to providing stronger state oversight of the Aging Waiver, including improved Quality Assurance initiatives and the implementation of a standardized rate-setting methodology. The initial phases of this rate-setting initiative will include the development of clearer service definitions along with interim steps designed to provide enhanced statewide oversight. A work plan is being submitted to reflect these changes

We look forward to working with the Centers for Medicare and Medicaid to better serve people under this important program.

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

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

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- A. The **State of Pennsylvania** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):  
**Pennsylvania's Home and Community-Based Waiver for Individuals Aged 60 and Over (Aging Waiver)**
- C. **Type of Request: renewal**

**Migration Waiver** - this is an existing approved waiver

**Renewal of Waiver:**

Provide the information about the original waiver being renewed

**Base Waiver Number:**

**Amendment Number**

(if applicable):

**Effective Date:** (*mm/dd/yy*)

**Waiver Number: PA.0279.R03.00**

**Draft ID: PA.13.03.00**

**Renewal Number:**

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

Regular Waiver

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

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 in 42 CFR §440.160** **Nursing Facility**

Select applicable level of care

 **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

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

 **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140** **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

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

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

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:

## 2. Brief Waiver Description

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

Pennsylvania's Home and Community-Based Waiver for Individuals Aged 60 and Over (Aging Waiver) provides home and community-based services to persons who meet the Nursing Facility level of care. The primary purpose of the waiver is to offer individuals the choice of receiving services in the community as an alternative to institutional care.

Pennsylvania is committed to promoting participant choice and participant direction. This commitment is evident throughout the Aging Waiver application. The Aging Waiver allows Pennsylvania to provide an alternative to institutional care by offering home and community based waiver services to individuals who require a Nursing Facility (NF) level of care.

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 Aging Waiver remains a component of the NHT initiative through the transition of individuals from a nursing facility setting to Aging Waiver services in a community setting.

This waiver application requests a new service definition, Financial Management Services. This renewal also removes Physician Services as an Extended State plan service. The initial phases of establishing a standardized rate-setting methodology will include a revision of the service definitions to increase clarity and eliminate overlapping provisions.

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

The performance of waiver operational and administrative functions at the local level is accomplished through contracts with fifty-two Area Agencies on Aging (AAAs) covering all sixty-seven counties in the commonwealth. OLTL as part of the State Medicaid Agency that oversees waiver operations within each of the local AAAs. The contracting function, specific to the Aging Waiver, has been transferred from the Pennsylvania Department of Aging (PDA) to the State Medicaid Agency (please see the work plan). The PDA role is limited to signing the contracts. All other functions related to the contracts are handled by OLTL. These contracts will be revised for State Fiscal Year 2009-2010, to reflect that OLTL is the part of the State Medicaid Agency which oversees waiver operations within each local AAA. Staffs, previously from PDA, responsible for oversight of all waiver operations have recently moved and are currently located within OLTL.

Waiver enrollment and Level of Care determinations occur at the local AAAs with direct oversight by OLTL. Services are provided through qualified providers that are enrolled as Medical Assistance providers. Currently, the AAAs perform bi-annual monitoring of enrolled waiver providers. Under the Quality Strategy component of the work plan, the OLTL Quality Management, Metrics and Analytics (QMMA) Unit as part of the State Medicaid Agency will perform annual monitoring of the AAAs and enrolled waiver providers to ensure compliance with Federal requirements.

AAA Care Managers are responsible for Service Plan development with input from the participant. Care Managers ensure that participants are receiving care and services to prevent institutionalization in accordance with 42 CFR Section 441.301.

Pennsylvania is also submitting a work plan to the Centers for Medicare and Medicaid Services (CMS) with this waiver renewal to address critical waiver assurance requirements. For example, the work plan includes (1) the process for transfer of the Aging Waiver contract signatures from the Department of Aging to the Office of Long Term Living, and other issues related to administrative oversight, (2) the steps Pennsylvania will take to implement a statewide rate-setting methodology and (3) improvement of the overall waiver Quality Assurance provisions.

An OLTL Organizational Chart is available to CMS upon request.

## 3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes. This waiver provides participant direction opportunities.** Appendix E is required.

**No. This waiver does not provide participant direction opportunities.** Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

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- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewidness.** Indicate whether the State requests a waiver of the statewidness requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

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

- Geographic Limitation.** A waiver of statewidness 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:*
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- Limited Implementation of Participant-Direction.** A waiver of statewidness 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:*
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#### 5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal

supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are 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:  
The State Medicaid Agency (OLTL) created the following avenues for participant and public participation and input into the development of the waiver renewal:

The OLTL sponsored and participated in six Regional Listening Sessions and two inclement weather make-up sessions. The session attendees included participants, families, local Area Agency on Aging representatives and local provider agency representatives. The OLTL provided an explanation of the Aging Waiver and proposed changes. Participants provided written and verbal comments. The OLTL also provided email address, mailing address, and telephone contact information for those who wished to provide additional comments outside of the sessions.

The Cash and Counseling Advisory Committee - an ongoing statewide advisory committee comprised of broad stakeholder groups including participants, family members, state staff, and providers, provided input and feedback on the expansion of participant direction in Pennsylvania.

The Long Term Care Sub-Committee and Consumer Sub-Committee of the Medical Assistance Advisory Committee also provide ongoing input and feedback on departmental waivers and services.

The Pennsylvania Association of Area Agencies on Aging (P4A) provides ongoing feedback on the Aging Waiver and services.

The Department of Welfare (DPW) Stakeholders' 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 DPW manages a website that offers program and contact information about the waivers. Stakeholders can contact the OLTL via the ra-acwrenewal@state.pa.us or PW, OLTLsupports@state.pa.us emails. These email messages go to the OLTL and are tracked

to ensure follow-up and response.

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 Aging Waiver renewal process.

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Pennsylvania**

**Zip:**

**Phone:**  **Ext:**   **TTY**

**Fax:**

**E-mail:**

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Pennsylvania**

**Zip:**

**Phone:**  **Ext:**   **TTY**

**Fax:**

**E-mail:**

## 8. Authorizing Signature

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This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

<b>Signature:</b>	John Michael Hall State Medicaid Director or Designee
<b>Submission Date:</b>	Oct 31, 2008
<b>Last Name:</b>	Richman
<b>First Name:</b>	Estelle B.
<b>Title:</b>	Secretary
<b>Agency:</b>	Department of Public Welfare
<b>Address:</b>	P.O. Box 2675
<b>Address 2:</b>	Health and Welfare Building
<b>City:</b>	Harrisburg
<b>State:</b>	Pennsylvania
<b>Zip:</b>	17105-2675
<b>Phone:</b>	(717) 787-2600
<b>Fax:</b>	(717) 772-2062
<b>E-mail:</b>	erichman@state.pa.us

### 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.

**The 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 Aging Waiver.

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

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

## Appendix A: Waiver Administration and Operation

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

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

- 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. Area Agencies on Aging can be either governmental or non-governmental entities.

There are written contracts with each of the 52 local Area Agencies on Aging (AAAs) covering all 67 Pennsylvania counties to provide intake and enrollment of participants into the Aging Waiver, perform Level of Care Assessments, perform annual Level of Care reevaluations, authorize services, and certify providers. 35 of the AAAs are non-state public agencies.

The Pennsylvania Department of Aging signs the contracts with the Area Agencies on Aging to provide intake and enrollment of participants, perform Level of Care Assessments, perform annual Level of Care reevaluations, authorize services, and certify providers. Administration and oversight of the contracts falls within the OLTL. The signing of these contracts will be transferred from the PDA to the OLTL for state fiscal year 09-10. More information is contained in the Administrative Authority section of the work plan.

Provide Intake and Enrollment- OLTL has a contract with AAAs to provide Intake and Enrollment for Aging Waiver participants. AAAs provide a level of care assessment and complete all required forms to assist participants in obtaining the necessary services.

Level of Care Assessments- A component of the Level of Care Assessment is contracted out to 52 local Area Agencies on Aging. A physician completes an MA-51 form or prescription indicating the physician's diagnosis and level of care recommendation 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.

Level of Care Reevaluations- OLTL has a contract with AAAs to perform annual reevaluations for participants already enrolled in the waiver.

Authorize Services- OLTL has a contract with AAAs to authorize services for the Aging Waiver. AAA Care Managers develop service plans to meet the needs of waiver participants.

Certify Providers- OLTL has a contract with AAAs to certify providers of waiver services. AAAs act on behalf of the OLTL when they distribute, collect and forward the paperwork to OLTL for providers to become enrolled Aging Waiver providers. OLTL acting as part of the State Medicaid Agency has the final authority for enrollment or certification of providers. The AAA sends the application materials to OLTL with a recommendation for enrollment or denial of enrollment and OLTL then proceeds with the remaining enrollment or notifies the potential provider that they do not meet the standards required to enroll as an Aging Waiver provider.

- 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. Area Agencies on Aging can be either governmental or non-governmental entities.

There are written contracts with each of the 52 local Area Agencies on Aging (AAAs) covering all 67 Pennsylvania counties to provide intake and enrollment of participants into the Aging Waiver, perform Level of Care Assessments, perform annual Level of Care reevaluations, authorize services, and certify providers. 17 of the AAAs are non-governmental non-state private agencies.

The Pennsylvania Department of Aging signs the contracts with the Area Agencies on Aging to provide intake and enrollment of participants, perform Level of Care Assessments, perform annual Level of Care reevaluations, authorize services, and certify providers. Administration and oversight of the contracts falls within the OLTL. The signing of these contracts will be transferred from the PDA to the OLTL for state fiscal year 09-10. More information is contained in the Administrative Authority section of the work plan.

Provide Intake and Enrollment- OLTL has a contract with AAAs to provide Intake and Enrollment for Aging Waiver participants. AAAs provide a level of care assessment and complete all required forms to assist participants in obtaining the necessary services.

Level of Care Assessments- A component of the Level of Care Assessment is contracted out to 52 local Area Agencies on Aging. A physician completes an MA-51 form or prescription indicating the physician's diagnosis and level of care recommendation 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.

Level of Care Reevaluations- OLTL has a contract with AAAs to perform annual reevaluations for participants already enrolled in the waiver.

Authorize Services- OLTL has a contract with AAAs to authorize services for the Aging Waiver. AAA Care Managers develop service plans to meet the needs of waiver participants.

Certify Providers- OLTL has a contract with AAAs to certify providers of waiver services. AAAs act on behalf of the OLTL when they distribute, collect and forward the paperwork to OLTL for providers to become enrolled Aging Waiver providers. OLTL acting as part of the State Medicaid Agency has the final authority for enrollment or certification of providers. The AAA sends the application materials to OLTL with a recommendation for enrollment or denial of enrollment and OLTL then proceeds with the remaining enrollment or notifies the potential provider that they do not meet the standards required to enroll as an Aging Waiver provider.

## Appendix A: Waiver Administration and Operation

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

The Office of Long Term Living (OLTL) oversees the local Area Agencies on Aging for day to day operations of the Aging Waiver. OLTL retains administrative authority as part of the State Medicaid Agency (SMA) and provides oversight of all delegated functions as outlined in the Administrative Authority and Quality Improvement sections of the work plan.

## Appendix A: Waiver Administration and Operation

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

The Office of Long Term Living (OLTL) oversees and monitors the performance of the provision of intake and enrollment of participants, Level of Care Assessments, authorization of services, and certification of providers through biannual onsite operational reviews, ongoing review of data, utilization management, and annual participant satisfaction surveys as outlined in the Quality Strategy section.

## Appendix A: Waiver Administration and Operation

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- 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	Local Non-State Entity
Participant waiver enrollment	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input type="checkbox"/>	<input checked="" type="checkbox"/>

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

**a. Methods for Discovery: Administrative Authority**

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

**i. Performance Measures**

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

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

**Performance Measure:**

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

		<b>Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: Assurances data collected through various performance measures
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

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

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

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

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Data Aggregation and Analysis:**

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

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Number and percent of reported remediation activities by non state entities to the Office of Long Term Living for new policy 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

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

**Data Aggregation and Analysis:**

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The Quality Management Efficiency Teams (QMETS) 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)**

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

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability 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
<input checked="" type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	60	64	
	<input type="checkbox"/>	Disabled (Other)			
<input type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/> Mental Retardation or Developmental Disability, or Both					
		Autism			

<input type="checkbox"/>					<input type="checkbox"/>
<input type="checkbox"/>	Developmental Disability				<input type="checkbox"/>
<input type="checkbox"/>	Mental Retardation				<input type="checkbox"/>
<input checked="" type="radio"/> <b>Mental Illness</b>					
<input type="checkbox"/>	Mental Illness				
<input type="checkbox"/>	Serious Emotional Disturbance				

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

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:*

This does not apply as there are no upper limits on age in this waiver. There is an issue with the on-line application where the fields in section B-1 of the application do not allow for entering the minimum age of 60 and no maximum age for the Aged target sub-group.

## 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	28481
Year 2	31350
Year 3	34325
Year 4 (renewal only)	37420
Year 5 (renewal only)	37615

- 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	23111
Year 2	25980
Year 3	28955
Year 4 (renewal only)	32050
Year 5 (renewal only)	32245

## 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 rebalancing 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 rebalancing demonstration

**Purpose** (describe):

In order to ensure the success of the Money Follows the Person Rebalancing Demonstration, Pennsylvania has reserved capacity within the Aging Waiver to serve participants in the demonstration. MFP participants will have access to all of the services available in the Aging Waiver.

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

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

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

Waiver Year	Capacity Reserved
Year 1	376
Year 2	751
Year 3	751
Year 4 (renewal only)	
Year 5 (renewal only)	

## Appendix B: Participant Access and Eligibility

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

- d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.
  - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.
- e. Allocation of Waiver Capacity.**

*Select one:*

- Waiver capacity is allocated/managed on a statewide basis.
- Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

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

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

1. Nursing Home Transition (NHT): Individuals who are currently receiving Medical Assistance in a nursing facility or those who are soon to be authorized for Medical Assistance and in a nursing facility and need waiver services to transition into the community.
2. Individuals who are at risk of nursing home placement. Individuals who currently reside in the community and are at imminent risk of nursing facility placement within 24-72 hours or less.

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

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- §1634 State  
 SSI Criteria State  
 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No  
 Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

**Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)**

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

*Select one:*

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

Specify percentage:

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

*Specify:*

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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:**

Select one:

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

Specify percentage:

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

Specify dollar amount:

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

Select one:

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

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

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

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the

42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

- The following standard included under the State plan**

*Select one:*

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

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

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

Specify:

- Other**

Specify:



---

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

---

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

Specify:

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

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

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

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

Specify:



---

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

---

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

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

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

Specify:

**Other**

Specify:

---

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

---

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

Select one:

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

Specify:

---

## 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.**

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

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## Appendix B: Participant Access and Eligibility

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

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

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

**i. Allowance for the personal needs of the waiver participant**

(select one):

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

Specify percentage:

**The following dollar amount:**

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

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

*Specify formula:*

**Other**

*Specify:*

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

Select one:

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

*Explanation of difference:*

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

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

Select one:

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

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

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

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

i. **Minimum number of services.**

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

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

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

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

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

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

*Specify the entity:*

**Other**

*Specify:*

The Area Agencies on Aging (AAA) Assessors conduct the initial component of the level of care assessments for individuals referred for waiver services. In addition a physician (M.D or D.O) completes an MA-51 form or prescription indicating the physician's diagnosis and level of care recommendation.

The AAA Assessors also conduct the annual reevaluations for participants that are already enrolled in the waiver. Reevaluations are conducted 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 of 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 of case work experience in the AAA system may be substituted for one year assessment experience.

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

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

Physicians

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

**d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care

instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

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

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

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

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

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

The Level of Care Determination is made using the Level of Care Assessment tool (LOCA) and 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 Aging Waiver services through the local Area Agency on Aging (AAA).
- The AAA assists the participant with obtaining a completed MA-51 or prescription from the participant's physician (M.D. or D.O.)
- A physician completes an MA-51 or prescription form indicating the physician's diagnosis and level of care recommendation.
- 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 AAA follows the status of the level of care determination process and assists with any required communication between the participant and the participant's physician.
- 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 AAA is responsible for completion of the annual reevaluation of the level of care.
- The AAA assessor visits the participant and uses the “Level of Care Assessment” (LOCA) form to identify information regarding the participant’s medical status, recent hospitalization, and functional ability (ADLs and IADLs).
- The AAA is responsible for making the final level of care 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:*

- 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*):

Area Agency on Aging (AAA) Assessors complete reevaluations annually and if the participant’s condition or circumstances change.

On an annual basis from the date the initial evaluation is completed, the Care Manager will meet with the participant in their home to reassess the participant’s need for waiver services and complete the Level of Care Assessment (LOCA) form. The Care Manager will be alerted to the Level of Care anniversary date through an automated notice from the Social Assistance Management System (SAMS). In addition, each AAA maintains its own tickler system to complete timely reevaluations and maintain consistency in service.

The Care Manager enters the reevaluation information into SAMS. Reevaluation documentation is also maintained in the participant’s file which is subject for review during OLTL annual monitoring visits.

AAA supervisory staff monitors reevaluation schedules monthly. OLTL monitors the timeliness of reevaluations through data extracts of the SAMS data system and through 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:

The Social Assistance Management System (SAMS)

The AAA Care Managers maintain copies of evaluations and reevaluation in the participant’s file

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

**Data Aggregation and Analysis:**

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

**Data Aggregation and Analysis:**

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

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

- 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**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = 95%+/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Clinical Review**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

- 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 consumer to identify other resources to meet their needs. The consumer 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 consumer is found eligible, waiver services will continue uninterrupted and OLTL will start recoupment procedures from the AAA for those services the consumer 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)**

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

**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 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.

**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 Aging 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 Area Agency on Aging (AAA) 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, by the AAA Care Manager, 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.

Participants will be afforded the opportunity for self direction upon enrollment in the waiver and upon reevaluation and participant request.

Documentation of the procedures for informing participants of their freedom of choice is located at <http://www.aging.state.pa.us>; click on Aging Program Directives link then Home and Community Based Services Procedure Manual.

- 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.

The form used to document participant freedom of choice between institutional and home and community-based services is maintained at the AAA in the participant's file.

## 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):

The Department of Public Welfare has translated waiver documentation into the following languages: Spanish, Russian, Vietnamese, Cambodian and Chinese. If another language or interpreter is required, the Care Managers are instructed to call 1-717-772-2525. Language assistance will be provided without charge.

Each Area Agency on Aging providing waiver services is required to have and implement policies and procedures for ensuring language assistance service to people who have limited proficiency in English.

## Appendix C: Participant Services

### 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	Adult Daily Living Services
Statutory Service	Home Health Care
Statutory Service	Home Support
Statutory Service	Personal Care
Statutory Service	Respite
Extended State Plan Service	Specialized Medical Equipment and Supplies

Supports for Participant Direction	Financial Management Services (FMS)
Other Service	Community Transition Services
Other Service	Companion Services
Other Service	Counseling
Other Service	Environmental Modifications
Other Service	Home Delivered Meals
Other Service	Personal Assistance Services
Other Service	Personal Emergency Response Service (PERS)
Other Service	TeleCare
Other Service	Transportation

## 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:**

Adult Day Health

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

Adult Daily Living Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Adult Daily Living services are comprehensive services provided to meet the personal care, social, nutritional, therapeutic and educational needs of individuals in a licensed center. The centers offer and are able to provide personal care services, day respite services, nursing services. Meals including special diets, individual health education sessions according to participant's care needs are included in this service. Meals as provided as part of the services shall not constitute a "full nutritional regimen" (3 meals per day). The center staff who provide the hands-on care to the individual, meet the minimum requirements of the service provider qualifications as if the services were stand alone waiver services. The plan of care drives the services an individual receives while at the center. Adult daily living services can be provided as a full day or a half day Transportation for waiver individuals is included in the rate for providers that provide transportation.

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

The individualized service plan will account for the services provided in the adult daily living facility and in the community/individual's residence to ensure there is no duplication or excess of needed like-services.

Adult Daily Living Services with transportation can not be provided at the same time as Transportation.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
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Agency	Adult Daily Living Facility
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## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Adult Daily Living Services**

**Provider Category:**

Agency

**Provider Type:**

Adult Daily Living Facility

**Provider Qualifications**

**License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Annually

## 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:**

Home Health Aide

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

Home Health Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Home Health Care consists of Home Health Care Aide, Nursing, Physical Therapy, Occupational Therapy and Speech Therapy Services.

Home Health Care Aide- services are provided by a supervised aide who may be a trained home health aide or a Licensed Practical Nurse. Home health activities include:

- Personal Care
- Performing simple measurements and tests to monitor participant's medical condition
- Assisting with ambulation
- Assisting with other medical equipment
- Assisting with exercises taught by a nurse or physical therapist
- Changing and/or reinforcing simple dressing on stable surface wounds
- Low level care of decubitus ulcers

- Caring for well-healed normal functioning colostomy
- Monitoring of dietary habits
- Assisting in retraining the client in self-help skills

Nursing- services must be performed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). 49 PA Code Chapter 21 (State Board of Nursing) provides the following service definition for the practice of professional nursing:

"Diagnosing and treating human responses to actual or potential health problems through such service as case finding, health teaching, health counseling, provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The term does not include acts of medical diagnosis or prescription of medical, therapeutic or corrective measures, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the Board, which rules and regulations will be implemented by the Board."

Services must be ordered by a physician.

Physical therapy- is provided by a licensed physical therapist based on a prescription by a physician, or recommendation by a physical therapist as documented in the service plan. Per the Physical Therapy Practice Act (63 P.S. §1301 et seq.) physical therapy "...means the evaluation and treatment of any person by the utilization of the effective properties of physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and rehabilitative procedures including training in functional activities, with or without assistive devices, for the purpose of limiting or preventing disability and alleviating or correcting any physical or mental conditions, and the performance of tests and measurements as an aid in diagnosis or evaluation of function."

Occupational therapy- services are direct services provided to assist individuals in the restoration of a skill that the individual previously had but lost. Services are provided as prescribed by a physician and outlined in a plan of care. The Occupational Therapy Practice Act (63 P.S. §1501 et seq.) defines occupational therapy as follows: "The evaluation of learning and performance skills and the analysis, selection and adaptation of activities for an individual whose abilities to cope with the activities of daily living, to perform tasks normally performed at a given stage of development and to perform essential vocational tasks which are threatened or impaired by that person's developmental deficiencies, aging process, environmental deprivation or physical, psychological, injury or illness, through specific techniques which include: (1) Planning and implementing activity programs to improve sensory and motor functioning at the level of performance for the individual's stage of development. (2) Teaching skills, behaviors and attitudes crucial to the individual's independent, productive and satisfying social functioning. (3) The design, fabrication and application of splints, not to include prosthetic or orthotic devices, and the adaptation of equipment necessary to assist patients in adjusting to a potential or actual impairment and instructing in the use of such devices and equipment. (4) Analyzing, selecting and adapting activities to maintain the individual's optimal performance of tasks to prevent disability."

Speech/language therapy- services are direct services provided to assist individuals in the restoration of a skill that the individual previously had but lost. Services are provided as prescribed by a physician and outlined in a plan of care. Speech and Language Therapy Services includes the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification, examination, diagnosis and treatment of conditions of the human speech language system, and including the examination for, and adapting and use of augmentative and alternative communication strategies, including, assistive devices and assistive technology.

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

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

Home Health Care Aide- Services can not be provided at the same time as Personal Assistance Services, Personal Care Services, Home Support Services or Companion Services.

Nursing, Physical Therapy, Occupational Therapy and Speech Therapy -State Medical Assistance Plan services may only be funded through the waiver when the service is not covered by the State Plan or private insurance. This may be because the State Plan or insurance limitations have been reached, or the service is not covered under the State Plan or private insurance. The Care Manager is responsible for verifying that the State Plan and/or private insurance limitations have been exhausted prior to funding services through the Aging Waiver. Documentation must be maintained in the individual's file by the Care Manager. This documentation must be updated annually.

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

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

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Home Health Aide
Agency	Home Health Agency

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Home Health Care**

**Provider Category:**

Individual

**Provider Type:**

Home Health Aide

**Provider Qualifications**

**License (specify):**

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

**Certificate (specify):**

Per 42CFR Part 484

Medicare Certification.

**Other Standard (specify):**

Individual Staff-

Home Health Aides, Registered Nurses, Licensed Practical Nurses, Physical Therapists, Occupational Therapists and Speech Therapists are licensed by The Pennsylvania Department of State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Home Health Care**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

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

**Certificate (specify):**

Per 42CFR Part 484

Medicare Certification

**Other Standard (specify):**

Individual Staff-

Home Health Aides, Registered Nurses, Licensed Practical Nurses, Physical Therapists, Occupational Therapists and Speech Therapists are licensed by The Pennsylvania Department of State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging  
**Frequency of Verification:**  
 Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Homemaker

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

Home Support

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Home Support consists of services to enable the individuals to maintain their private residence. Home Support must be provided by a qualified homemaker and includes: cleaning, laundry, meal preparation, and other general household care and services needed to maintain the home in a clean, sanitary, and safe condition. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Maintenance in the form of upkeep and improvements to the individual's residence is excluded from federal financial participation.

This service can only be provided in the following situations:

- Neither the individual, nor anyone else in the household, is capable of performing or financially providing for the function, and
- No other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision

Home support activities do not include hands on care related to a consumer's personal hygiene or functional activities of daily living.

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

Service is limited to needs determined during the assessment and identified in the service plan. Home support services can not be provided at the same time as Personal Assistance Services, Personal Care Services, Home Health Care Aide Services or Companion Services.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Personal Care/Homemaker Agency

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Home Support**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

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

**Certificate (specify):**

Per 42CFR Part 484

Medicare Certification

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Home Support**

**Provider Category:**

Agency

**Provider Type:**

Personal Care/Homemaker Agency

**Provider Qualifications**

**License (specify):**

Licensed /Registered by Department of Health under Act 69 of 2006 and Title 28 Pa. Code Chapter 51

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging

**Frequency of Verification:**

Annually

## 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):**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Personal Care is a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task related to personal hygiene or functional activities of daily living. This can include bathing, skin care, mouth care, dressing, grooming, toileting, ambulation and transfer, change of position or turning the participant, feeding, medication assistance with self-administration, observation, instruction to informal care givers. Personal care may include the provision of supplemental housekeeping as long as the primary service rendered is for the 'hands-on' care. Personal Care services can be provided in either a quarter hour or shift.

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

Participants are assessed for services, frequency of services and duration of services based upon needs and are identified and documented in the participant's plan of care.

Personal Care services can not be provided at the same time as Personal Assistance Services, Home Support Services, Home Health Care Aide Services or Companion Services.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Personal Care/Homemaker Agency

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Personal Care****Provider Category:**

Agency

**Provider Type:**

Home Health Agency

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

Licensed by Department of Health under  
Act 69 of 2006 and Title 28 Pa. Code Chapter 51

**Certificate (specify):**

Certified personal care aide/registered nurse aide Certification as required by specific profession or discipline, per  
42CFR Part 484

**Other Standard (specify):**

Staff:

Supervision by a registered nurse

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

---

**Service Type: Statutory Service**

**Service Name: Personal Care**

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**Provider Category:**

Agency

**Provider Type:**

Personal Care/Homemaker Agency

**Provider Qualifications**

**License (specify):**

Licensed /Registered by Department of Health under Act 69 of 2006 and Title 28 Pa. Code Chapter 51

**Certificate (specify):**

**Other Standard (specify):**

Staff:

Supervision by a registered nurse

Two years of professional work experience in a health care related capacity. If less than two years must provide one work reference and one personal reference.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Respite

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Respite services are services that are provided to supervise/support individuals on a short-term basis due to the absence or need

for relief of those persons normally providing care.

Federal and State financial participation through the waivers is limited to:

1. Services provided for individuals residing in their own unlicensed home or the unlicensed home of relative, friend, or other family.
2. Services provided in Medicaid-certified Hospital, Nursing Facility, or Foster Home.
3. Room and board costs associated with respite care services that are provided in a facility approved (licensed or accredited) by the State that is not a private residence are reimbursable. Room and board costs are excluded from respite services when the service is provided in a setting that is not facility-based and approved by the state.

Respite services furnished in a participant's home can be provided in either a quarter hour or shift. Respite services may also be provided in a long term care facility on a per diem basis.

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

Individuals are authorized for up to 14 consecutive days in an institutional facility. However with prior approval that may be increased up to 29 consecutive days.

Participants are assessed for services, frequency and duration based upon needs identified and documented in their service plan.

Respite services can not be provided at the same time as Personal Care, Personal Assistance Services, Home Support Services, or Companion Services.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Care Agency
Agency	Nursing Home
Agency	Personal Care/Homemaker Agency

## Appendix C: Participant Services

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

**Service Type:** Statutory Service

**Service Name:** Respite

**Provider Category:**

Agency

**Provider Type:**

Home Health Care Agency

**Provider Qualifications**

**License** (*specify*):

Licensed by Department of Health under Act 69 of 2006 and Title 28 Pa. Code

**Certificate** (*specify*):

Certification as required by specific profession or discipline, per 42CFR Part 484

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

**Provider Type:**

Nursing Home

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

Certification as required by specific profession or discipline, per 42CFR Part 484

**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

**Provider Type:**

Personal Care/Homemaker Agency

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

Licensed /Registered by Department of Health under Act 69 of 2006 and Title 28 Pa. Code Chapter 51

**Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Specialized Medical Equipment and Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the individualized service plan, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

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

The equipment and/or supplies provided are above and beyond those already supplied under the approved state plan. Participants are assessed for services, frequency and duration based upon needs identified and documented in their service plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Durable Medical Equipment and Supply Company
Agency	Home Health Agency
Agency	Pharmacy

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Specialized Medical Equipment and Supplies****Provider Category:**

Agency

**Provider Type:**

Durable Medical Equipment and Supply Company

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

Agency:

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

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

Area Agencies on Aging. Verification of Provider Qualifications will be further addressed in the Quality Strategy component of the work plan.

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


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**Service Type: Extended State Plan Service**

**Service Name: Specialized Medical Equipment and Supplies**

---

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

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

Licensed by Department of Health under Act 69 of 2006 and Title 28 Pa. Code

**Certificate (specify):**

Certification as required by specific profession or discipline, per 42CFR Part 484

**Other Standard (specify):**

Agency:

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

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

State Medicaid Agency

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


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**Service Type: Extended State Plan Service**

**Service Name: Specialized Medical Equipment and Supplies**

---

**Provider Category:**

Agency

**Provider Type:**

Pharmacy

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

**Certificate (specify):**

**Other Standard (specify):**

Agency:

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

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

Area Agencies on Aging.

Verification of Provider Qualifications will be further addressed in the Quality Strategy component of the work plan.

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Supports for Participant Direction 

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**

Information and Assistance in Support of Participant Direction 

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

Financial Management Services (FMS)

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**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/or 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 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 Care Manager, 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 a toll-free complaint line for participants to report concerns about their provider. Additional safeguards will be developed by OLTL as part of the Quality Improvement component 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; and 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 Pennsylvania State Insurance Fund (SWIF);
- 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 Care Manager

**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.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Vendor Fiscal/Employer Agents (VF/EA)
Agency	Government Fiscal/Employer Agents (GF/EA)

## Appendix C: Participant Services

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

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

**Provider Category:**

Agency

**Provider Type:**

Vendor Fiscal/Employer Agents (VF/EA)

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**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:**

State Medicaid Agency

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Provider Category:**

Agency

**Provider Type:**

Government Fiscal/Employer Agents (GF/EA)

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**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:**

State Medicaid Agency

**Frequency of Verification:**

Annually

## 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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**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. Expenditures may not include ongoing payment for rent. 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 – pest eradication, allergen control, one-time cleaning prior to occupancy;

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

Services not to exceed \$4000 per individual transition; these are non-recurring expenses

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Transitional Service Provider
Agency	Area Agency on Aging

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Community Transition Services**

**Provider Category:**

Agency

**Provider Type:**

Transitional Service Provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

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

State Medicaid Agency

**Frequency of Verification:**

At Time of Service

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Community Transition Services**

**Provider Category:**

Agency

**Provider Type:**

Area Agency on Aging

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

**Certificate (specify):**

**Other Standard (specify):**

Area Agencies on Aging must meet all applicable federal or state requirements related to the service to be rendered.

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

State Medicaid Agency

**Frequency of Verification:**

At time of service

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Companion Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Companion Services provide limited non-medical care, supervision and minimal assistance with daily living activities to functionally impaired adults. Companions may assist the individual with tasks such as verbal cuing, meal preparation and planning and socialization. The provision of companion services does not entail hands-on care.

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

Companion services can not be provided at the same time as Personal Assistance Services, Home Support Services, Home Health Care Aide Services or Personal Care Services.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Personal Care/Homemaker Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Companion Services**

**Provider Category:**

Agency

**Provider Type:**

Personal Care/Homemaker Agency

**Provider Qualifications**

**License** (specify):

Licensed /Registered by Department of Health under Act 69 of 2006 and Title 28 Pa. Code Chapter 51

**Certificate** (specify):

**Other Standard** (specify):

Agency:

55PA Code

Staff:

At least 18 years old

Criminal clearances

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging

**Frequency of Verification:**

Annually

## 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:**

## Counseling

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Counseling services are short-term goal-oriented therapeutic sessions designed to restore, remediate or rehabilitate. The sessions improve functioning and independence and can be provided for problem solving, development of coping skills, nutrition education, substance abuse issues, individual/marital/family stress, behavioral and end of life issues. The cognitive, affective, behavioral or systematic intervention strategies and services promote wellness and personal growth in addition to addressing pathology.

There are numerous provider options for counseling services.

- A registered dietician is limited to nutrition education only.
- A licensed social worker may not provide nutrition counseling but may address the other issues.
- A psychiatric adult mental health clinical or educational psychologist may not provide nutrition counseling but may address the other issues.
- A home health agency may provide services to the extent the agency has certified staff with expertise in the service need.
- An out-patient rehabilitation agency may provide services to the extent the agency has certified staff with expertise in the service need.
- A behavioral therapy provider may provide services to the extent the agency have certified staff with expertise in the service need.

**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.

Counseling Services may only be funded through the waiver when the service is not covered by the State Plan or private insurance. This may be because the State Plan or insurance limitations have been reached, or the service is not covered under the State Plan or private insurance. The Care Manager is responsible for verifying that the State Plan and private insurance limitations have been exhausted prior to funding services through the Aging Waiver. Documentation must be maintained in the individual's file by the Care Manager. This documentation must be updated annually.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Licensed Social Worker
Agency	Out-Patient Rehabilitation Agency/Behavioral Therapy Provider
Individual	Psychiatric Adult Mental Health Clinical or Educational Psychologist
Individual	Registered Dietician
Agency	Home Health Agency

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Counseling**

**Provider Category:**

Individual **Provider Type:**

Licensed Social Worker

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

State Board of Social Workers, Marriage and Family Therapists and Professional Counselors 49 PA. CODE, Chapter 41, Chapter 47, 48 and 49.

**Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Counseling****Provider Category:**Agency **Provider Type:**

Out-Patient Rehabilitation Agency/Behavioral Therapy Provider

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

License as required by specific profession or discipline

**Certificate (specify):**

Comprehensive Outpatient Rehabilitation Facility (CORF) Certification

**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Counseling****Provider Category:**Individual **Provider Type:**

Psychiatric Adult Mental Health Clinical or Educational Psychologist

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

State Board of Psychology Professional Psychologists Practice Act, 63 P.S. §§ 1201-1218. 49 PA. CODE, Chapter 41.

**Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Counseling****Provider Category:**Individual **Provider Type:**

Registered Dietician

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

PA STATE BOARD OF DIETITIAN-NUTRITIONIST 49 Pa Code, Chapter 21

**Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Counseling****Provider Category:**Agency **Provider Type:**

Home Health Agency

**Provider Qualifications****License (specify):**Licensed by Department of Health under  
Act 69 of 2006 and Title 28 Pa. Code**Certificate (specify):**Certification as required by specific profession or discipline, per  
42CFR Part 484**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Annually

**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:**

Environmental Modifications

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Physical adaptations to the private residence of the participant or the participant's family identified in the participant's service plan, necessary to ensure the health, welfare and safety or that enables the participant greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary for the welfare of the participant.

Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant are excluded. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

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

All modification or adaptations that exceed \$6,000 must be reviewed by the SMA

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Contractor

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type:** Other Service

**Service Name:** Environmental Modifications

**Provider Category:**

Individual

**Provider Type:**

Contractor

**Provider Qualifications**

**License (specify):**

Contractor's license for state of Pennsylvania

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging

Verification of Provider Qualifications will be further addressed in the Quality Strategy component of the work plan.

**Frequency of Verification:**

At time of service

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Home Delivered Meals

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

The Home Delivered Meal Service provides meals that meet the 1/3 RDA requirements to people in their homes. Individuals may receive more than one meal per day but they cannot receive meals that constitute a “full nutritional regimen” (three meals per day). Participants can receive either a full meal or sandwich pack.

Participants are given a choice between all qualified providers in their service area. Area Agencies on Aging are not permitted to solicit donations from recipients of home delivered meals through the Aging Waiver.

The transportation cost for meals is covered through the rate of the meal.

This Service Definition will be developed further under the rates component of the work plan.

**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.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Vendors of Home Delivered Meals

## Appendix C: Participant Services

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

Service Type: Other Service

**Service Name: Home Delivered Meals****Provider Category:**

Agency

**Provider Type:**

Vendors of Home Delivered Meals

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

Safe food handling, preparation and transportation standards conform with Title 7 PA Code Chapter 45, Food Code

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

Area Agency on Aging

Verification of Provider Qualifications will be further addressed in the Quality Strategy component of the work plan.

**Frequency of Verification:**

Annually

**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 Assistance Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

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

Personal Assistance Services are provided through the following models:

**Agency Model**

In the Agency Model, a provider has employer direction over individuals employed to provide Personal Assistance Services. The provider is responsible for hiring, firing, scheduling, all payroll tasks, and supervisory activities for each employee. (Identified in Appendix J as Personal Assistance Service Agency)

**Consumer Employer Model**

In the Consumer Employer Model, the participant has employer authority over individuals employed to provide Personal Assistance Services. Participants in the Consumer Employer Model hire, fire, schedule, and supervise their personal assistants. A participant chooses an enrolled FMS provider to provide financial management services, information and assistance in support of participant direction. (Identified in Appendix J as Personal Assistance Service Consumer Employer)

Personal Assistance Services include:

Providing assistance to the participant with eating, bathing, dressing, personal hygiene, and other activities of daily living (ADL).

Assistance with the preparation of meals, but does not include the cost of the meals themselves.

Such light housekeeping chores as bed making, dusting, and vacuuming, and other activities of daily living which are incidental to the care furnished or which are essential to the health and welfare of the individual rather than the individual's family.

Health maintenance activities are provided for the participant, such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the Individual Service Plan (ISP).

Routine wellness services to enable adequate nutrition, exercise, keeping of medical appointments and all other health regimens related to healthy living activities.

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

Personal Assistance services can not be provided at the same time as Companion Services, Home Support Services, Home Health Care Aide Services or Personal Care Services.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Personal Care/Homemaker Agency
Individual	Personal Assistance Worker
Agency	Attendant Care Provider Organization

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Personal Assistance Services**

**Provider Category:**

Agency

**Provider Type:**

Personal Care/Homemaker Agency

**Provider Qualifications**

**License** (specify):

Licensed /Registered by Department of Health under Act 69 of 2006 and Title 28 Pa. Code Chapter 51

**Certificate** (specify):

**Other Standard** (specify):

Attendants must:

- Be 18 years of age or older;
- Have the required skills to perform attendant care services as specified in the consumer's service plan;
- Possess a valid Social Security number;
- Submit to a criminal records check and child abuse clearances; and

When required by the consumer, the attendant must be able to demonstrate the capability to perform health

maintenance activities specified in the consumer's service plan or receive necessary training

Agency:

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

- Commercial General Liability Insurance

- Professional Liability Errors and Omissions Insurance

- Worker's Compensation Insurance, when required by Pennsylvania statute

- Must meet requirements of 55PA Code

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Bi-Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Personal Assistance Services**

**Provider Category:**

Individual

**Provider Type:**

Personal Assistance Worker

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Attendants must:

- Be 18 years of age or older;
- Have the required skills to perform attendant care services as specified in the consumer's service plan;
- Possess a valid Social Security number;
- Submit to a criminal records check and child abuse clearances; and

When required by the consumer, the attendant must be able to demonstrate the capability to perform health maintenance activities specified in the consumer's service plan or receive necessary training

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Bi-Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Personal Assistance Services**

**Provider Category:**

Agency

**Provider Type:**

Attendant Care Provider Organization

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

Licensed /Registered by Department of Health under Act 69 of 2006 and Title 28 Pa. Code Chapter 51

**Certificate (specify):**

**Other Standard (specify):**

Attendants must:

- Be 18 years of age or older;
- Have the required skills to perform attendant care services as specified in the consumer's service plan;
- Possess a valid Social Security number;
- Submit to a criminal records check and child abuse clearances; and

When required by the consumer, the attendant must be able to demonstrate the capability to perform health maintenance activities specified in the consumer's service plan or receive necessary training

**Agency:**

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

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

State Medicaid Agency

**Frequency of Verification:**

Bi-Annually

**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:**


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 Service (PERS)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**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 and maintenance are included in this service.

**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.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Vendors of Personal Emergency Response Systems
Agency	Home Health Agency

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


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


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**Provider Category:**

**Provider Type:**

Vendors of Personal Emergency Response Systems

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

**Certificate** (specify):

**Other Standard** (specify):

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.

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

Area Agency on Aging

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


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


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**Provider Category:**

**Provider Type:**

Home Health Agency

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

Licensed by Department of Health under Act 69 of 2006 and Title 28 Pa. Code

**Certificate** (specify):

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging

**Frequency of Verification:**

Annually

## 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:**

TeleCare

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

TeleCare is a model of care that integrates social and healthcare services that are supported by innovative technologies to sustain and promote independence, quality of life and reduce the need for nursing home placement. TeleCare includes Health Status Measuring and Monitoring Services, Medication Dispensing and Passive Safety Monitoring. By utilizing in-home technology, more options are available to assist and support individuals so that they can remain in their own homes.

- Health Status Measuring and Monitoring: Using wireless technology or a phone line, this service includes electronic communication between the consumer and healthcare provider that focuses on collecting vital signs information such as pulse oximetry and blood pressure that assists the healthcare provider in assessing the consumer's condition, and providing education and consultation. Must be ordered by a physician and provided by a Home Health Agency. Physiological Monitoring includes installation and daily monitoring.
- Activity and Sensor Monitoring: This type of service employs sensor-based technology on a 24/7 day basis by remotely monitoring and passively tracking consumers' daily routines and may report on the following: wake up times, overnight bathroom usage, potential bathroom fall, medication usage, meal preparation and room temperature. Activity and Sensor Monitoring includes installation and monthly monitoring.
- Medication Dispensing and Monitoring: To assist consumers by dispensing and monitoring medication compliance. Remote monitoring system that is personally pre-programmed for each consumer to dispense and monitor compliance and notifies the provider or family caregiver of missed doses or non-compliance with medication therapy.

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

All TeleCare participants are assessed for service, frequency, and duration of service based upon needs identified and documented in the participant's individual service plan. Participants can only receive TeleCare services when they meet eligibility criteria specified in the TeleCare Services APD and the services are not covered under by Medicare or other third party resources. The Care Manager is responsible for verifying that third party limitations have been exhausted prior to funding services through the Aging Waiver. Documentation that the services are not available must be maintained in the individual's file and updated annually.

Medication Dispensing services can not be provided at the same time as Personal Assistance Services, Personal Care Services, Home Health Care Aide Services or in-home Respite Services.

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

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

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

Legally Responsible Person

Relative

Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Hospital
Agency	Medical Equipment and Supply Company
Agency	Pharmacy
Agency	Personal Care/Homemaker Agency
Agency	Home Health Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: TeleCare**

**Provider Category:**

Agency

**Provider Type:**

Hospital

**Provider Qualifications**

**License (specify):**

Licensed through the PA Department of Health, per 28 PA Code Subpart B

**Certificate (specify):**

Certification as required by specific profession or discipline, per 42CFR Part 482

**Other Standard (specify):**

Agency:

Meet provider requirements as specified in the TeleCare Services Directive APD

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: TeleCare**

**Provider Category:**

Agency

**Provider Type:**

Medical Equipment and Supply Company

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Agency:

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: TeleCare****Provider Category:**

Agency

**Provider Type:**

Pharmacy

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

Agency:

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

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

State Medicaid Agency

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: TeleCare****Provider Category:**

Agency

**Provider Type:**

Personal Care/Homemaker Agency

**Provider Qualifications****License (specify):**Licensed /Registered by Department of Health under  
Act 69 of 2006 and Title 28 Pa. Code Chapter 51**Certificate (specify):****Other Standard (specify):**

Agency:

Meet provider requirements as specified in the TeleCare Services Directive APD  
55PA Code

Staff:

At least 18 years old

Trained and Certified by Telecare equipment vendor in the installation, maintenance, monitoring and repair of the  
units that are being used by the agency.**Verification of Provider Qualifications****Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

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**Service Type: Other Service**  
**Service Name: TeleCare**

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**Provider Category:**

**Provider Type:**

Home Health Agency

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

Licensed by Department of Health under  
 Act 69 of 2006 and Title 28 Pa. Code

**Certificate (specify):**

Certification as required by specific profession or discipline, per  
 42CFR Part 484

**Other Standard (specify):**

Agency:

Meet provider requirements as specified in the TeleCare Services Directive APD

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

State Medicaid Agency

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**


As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the individualized service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

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

State plan (SP) transportation services will be used for SP services. The individual's service plan must document the need for waiver transportation services.

Transportation cannot be provided at the same time as Adult Daily Living Services with transportation.

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

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

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Transportation Agency, Public Transit Authority
Individual	Individual Driver

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Transportation**

**Provider Category:**

Agency

**Provider Type:**

Licensed Transportation Agency, Public Transit Authority

**Provider Qualifications**

**License (specify):**

Licensed by the P.U.C and/or be a Public Transit Authority, a Community Transportation Provider or Community Transportation Subcontractor

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging

Verification of Provider Qualifications will be further addressed in the Quality Strategy component of the work plan.

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Transportation**

**Provider Category:**

Individual

**Provider Type:**

Individual Driver

**Provider Qualifications**

**License (specify):**

Valid Pennsylvania driver's license

**Certificate (specify):**

**Other Standard (specify):**

Drivers must meet the following:

-18 years of age

--Receive physical examination (including a vision test) at the time of hire and at least every 2 years

--Be willing to provide door-to-door services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency On Aging

**Frequency of Verification:**

Annually

## 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:

Fifty-two (52) local Area Agencies on Aging provide case management to 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):

Pursuant to the Older Adults Protective Services Act (OAPSA), criminal history background investigations are required for all employees, operators and administrators of the following facilities: domiciliary care homes, home health care agencies, long-term care nursing facilities, older adult daily living centers, and personal care homes.

To ensure that all participants make informed choice of service and service delivery, the OLTL is exploring making criminal history background checks mandatory for personal assistance workers and support workers who are employed by a participant or their representatives. Participants and their representatives have the right to request a criminal history background check and to employ a worker regardless of the outcome of the background check.

Currently, criminal history background checks for individuals who have resided in Pennsylvania for at least two years are obtained from the Pennsylvania State Police and must be submitted at time of application for employment. The completed criminal history background check must have been obtained within the preceding one-year period. The Pennsylvania State Police access the Pennsylvania Crime Information Center (PCIC) for this information. For applicants who have not resided in Pennsylvania for at least two years, a Federal Bureau of Investigation (FBI) federal criminal history record is required.

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

Fiscal/Employer Agents (F/EA) must have a system and a written policy and procedure for obtaining permission from and performing criminal history background checks on prospective support workers when requested by individuals and their representatives. The cost of conducting criminal history background checks is included in the monthly per member rate paid to

the F/EA. In addition, the F/EA must have a system in place to document the following:

- The individual and their representative wish to have a background check conducted;
- The individual and their representative do not wish to have a background check conducted;
- The individual and their representative’s decision to employ a support worker with a criminal record and their acceptance of responsibility for their decision.

**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/provider 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 documented.

## Appendix C: Participant Services

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

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

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

## Appendix C: Participant Services

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### C-2: Facility Specifications

**Facility Type:**

Domiciliary Care homes certified by the PA Department of Aging

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility

Respite	<input checked="" type="checkbox"/>
Companion Services	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input checked="" type="checkbox"/>
Personal Emergency Response Service (PERS)	<input checked="" type="checkbox"/>
Personal Assistance Services	<input type="checkbox"/>
Financial Management Services (FMS)	<input type="checkbox"/>
Adult Daily Living Services	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Home Support	<input type="checkbox"/>
Transportation	<input checked="" type="checkbox"/>
Personal Care	<input type="checkbox"/>
TeleCare	<input type="checkbox"/>
Community Transition Services	<input type="checkbox"/>
Environmental Modifications	<input checked="" type="checkbox"/>
Counseling	<input checked="" type="checkbox"/>
Home Health Care	<input type="checkbox"/>

**Facility Capacity Limit:**

3

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

**Scope of State Facility Standards**

Standard	Topic Addressed
Admission policies	<input type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input type="checkbox"/>
Staff : resident ratios	<input type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

Not 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.*

Payment may be made to any otherwise qualified person who is NOT a legal guardian, power of attorney, spouse or designated representative directing services on behalf of the participant. Relative as described must meet the same qualifications as any other provider for any waiver service. The FMS provider will review time sheets for required documentation, including hours worked and tasks accomplished, prior to issuing a payment check to the relative.

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

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

Local AAAs review qualification of providers and assist an agencies or individual providers with the process of enrolling as a new Aging Waiver service provider. AAA staff guides the agency or provider of service in preparing an enrollment application. This application must be submitted to the OLTL acting as part of the State Medicaid Agency 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) Medicaid Home and Community Based Waiver Program Survey
- 4) PROMISe Enrollment Form

AAA staff provides technical assistance to the prospective provider in obtaining the appropriate documentation. The AAA submits the enrollment packet to OLTL.

The OLTL Quality Management Unit (QMU) will be responsible for reviewing the credentials of all potential providers and assisting them through the application process.

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:

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

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

**Data Aggregation and Analysis:**

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

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

**Data Aggregation and Analysis:**

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

- 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, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

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

**Data Aggregation and Analysis:**

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

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

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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

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 not have 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)**

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

**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 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.

**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:

Untitled

- 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:*

The Local Area Agencies on Aging (AAA) conduct Service Plan development to ensure participants are receiving care and services to prevent institutionalization in accordance with 42 CFR Section 441.301.

The AAA Care Manager provides the participant with the opportunity to engage in the service plan development process to the extent they desire, ensures the planning process and assessment of needs is timely, and ensures services are adequate to meet the needs of the participant. Participants may include family, friends, advocates or others as part of their ISP development.

AAA Care Manager

- One year aging Care Manager 2 or

- 2 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 of case work 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. Unrelated experience or education will not be accepted.

Care Managers are be responsible for the ongoing monitoring of the provision of services included in the participant's service plan. Service plans are reviewed and/or revised at least annually (every 365 days) or when there are changes in the participant's needs.

**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:*

The Office of Long Term Living (OLTL) as part of the State Medicaid Agency (SMA) requires the following safeguards to ensure that service plan development is conducted in the best interests of the participant.

The AAA assures that all eligible participants are given a choice of service providers during the enrollment process and before services begin and at anytime during the year when a participant requests a change of providers. At the time of enrollment and at each reevaluation the Care Manager fully informs the participant of the choices of the providers.

OLTL recognizes the need to strengthen safeguards in this area. OLTL is developing a standardized form entitled the "Waiver Service Provider Choice Form" that all AAAs must present and explain to participants at the time of enrollment and at each subsequent annual reevaluation. Notation will be made in the participant's record to document receipt of the form. Completed forms will be maintained in the participants file at the AAA. OLTL will monitor receipt of the forms as part of annual reviews. This standard form and process is detailed in the attached work plan.

OLTL currently provides a toll-free complaint line for participants of other OLTL waivers and programs to report concerns about their provider. OLTL will enhance this toll-free complaint line and conduct outreach efforts to the Aging Waiver population to ensure that Aging Waiver participants have this additional resource for reporting concerns about their provider. This toll-free complaint line information will be incorporated into the Waiver Service Provider Choice Form. This is addressed in the attached work plan.

## 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 Care Manager. The participant drives the process and has the right to include family, friends, advocates or others as part of their ISP development.

The Care Manager assists the participant in the development of the service plan and ensures to the fullest extent possible that the participant is able to express their own input into the development of their service plan.

A key step in developing an ISP is for the Care Manager to gather information that reflects the needs and preferences of the participant. Information may also be obtained from 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, someone identified by the participant that has a close enough relationship with the participant to accurately speak on their behalf, or an interpreter.

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. The ISP identifies services based on the participant's need and expressed preferences.

Prior to the meeting(s), the Care Manager 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).

## **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 Supports Plan (ISP), also known as the service plan, contains essential information about the individual, which is used for planning and implementing support 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 Care Manager develops the service plan utilizing a participant-centered approach. This process involves the Care Manager, the participant, and others as identified at the participant's request, such as family members or friends.

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

The ISP is developed within timeframes indicated by the applicable licensed service regulations and/or policies for non-licensed services and are developed prior to the implementation of services.

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

The Care Manager discusses potential revisions with the participant. When there is a potential change in the ISP, the care Manager enters that change through the Social Assistance and Management System (SAMS) and shares the update with the participant and service providers. The Office of Long Term Living is developing a process to ensure plans are updated annually and address participant's changing needs as part of the work plan.

-The types of assessments that are conducted:

The Care Manager uses the Care Management Instrument (CMI) in the development of the service plan. The Care Manager completes the CMI in collaboration with the participant or their representative and others at the participant's request when an

individual applies for the Aging Waiver, at the annual reevaluation, or as service needs change. The CMI 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 ISP. The Care Manager also gleans additional information from the LOCA tool and physician's diagnosis.

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

Care Managers are responsible to ensure that all waiver participants are informed of home and community-based services funded through the Aging Waiver. The Care Manager describes and explains the concept of participant-centered service planning to the participant at home visits and through ongoing discussions with the participant. The Care Manager also informs the participant of the types of services available through the Aging Waiver at home visits and through ongoing discussions with the participant.

-How the plan development process ensures that the service plan addresses participant goals, needs, and preferences:

ISP's are based on a written assessment or other documentation that supports the individual's need for each waiver funded service

The Care Manager completes the CMI in conjunction with the participant or their representative and others at the participant's request. The CMI secures information about the participant's strengths, capacities, needs, preferences, health status, risk factors, and desired goals. It also includes other necessary medical, functional, cognitive/emotional and social information used to develop the participant's ISP.

SAMS stores information from the collaboration between the participant and the Care Manager. Storing the plan electronically in SAMS affords Care Managers quick accessibility to plan information. Participant service plans and the process of developing service plans is being improved as specified in the work plan.

The Care Manager gathers information on an ongoing basis to assure the ISP reflects the participants' needs. Revisions are discussed with the participant and entered into SAMS and the updated service information is shared with the participant and service providers.

-How responsibilities are assigned for implementing the plan:

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

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

-How the process addresses participants' health care needs:

The Care Manager 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 SAMS. 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 Care Manager, the participant, and others of the participant's choosing consider all other potential sources of coverage as part of the service plan development process. The team reviews for any service coverage that may be available under the State Plan or other possible Federal programs before utilizing waiver services. The team also reviews for the availability of informal supports in the person's community such as friends, family, neighbors, local businesses, schools, civic organizations and employers. Coordination of these services is guided by the principles of preventing institutional placement and protecting the

participant's health and welfare. Services are outlined in the participant's ISP, which is distributed by the Care Manager to the participant and their representative and providers of service. The Care Manager is responsible to ensure that there is coordination between services in the ISP, including maintaining collaboration between OLTL sponsored services and informal supports, as well as ensuring consistency in service delivery among providers.

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

Upon authorization of the ISP, the AAA ensures that supports and services are implemented and that each provider is accountable for services as assigned.

The Care Manager gathers information on an ongoing basis to assure the ISP reflects the participants' needs. Revisions are discussed with the participant and entered into SAMS and shared with the participant and service providers.

The Care Manager reviews the ISP annually or more frequently if needed to assure that the information is complete and accurate and that services are implemented as recommended. Care Manager monitoring ensures that reasonable safeguards exist for the person's health and well-being in the home and community. The Care Manager monitors the health and safety of the participant and the quality of services provided to the participant through personal visits and telephone calls. A monthly contact in some form, either home visit or telephone, is required for all participants. Personal visits and telephone contacts may be done more frequently as needed and agreed upon by the participant and team to assure provision of services and health and welfare of the participant.

OLTL monitors ISPs as part of the annual monitoring for compliance with waiver requirements and ISP policies. OLTL currently provides a toll-free complaint line for participants of other OLTL waivers and programs to report concerns about their provider. OLTL will enhance this toll-free complaint line and conduct outreach efforts to the Aging Waiver population to ensure that Aging Waiver participants have this additional resource for reporting concerns about their provider. This is addressed in the attached work plan.

## 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 Care Manager will discuss these potential risks with the participant and whomever the participant chooses to have present such as providers, the participant's family and friends during the development of the ISP. The Care Manager, participant and any other participant chosen individuals will identify strategies to mitigate such risks that will allow participants to live as they choose in the community while assuring their health and welfare. These strategies will be incorporated into the ISP. The Care Manager will also describe any unique circumstances on the service plan. The Care Manager will identify if any of the services available through the waiver would be appropriate for the participants' circumstances. The Care Manager 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.

An example of a service that may benefit a participant in this type of situation is the Personal Emergency Response System (PERS). In order to be eligible for PERS, a waiver participant must live alone, or be alone for significant parts of the day, have no regular caregiver for extended periods of time, and would otherwise require extensive routine supervision. This service is further explained in Appendix C-3: Waiver Services Specifications.

Currently, emergency back up plans and priority arrangements to ensure the health 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 Care Manager level. All participants are required to have individualized back up plans and arrangements to cover the personal assistance services they need when the regularly scheduled personal assistance 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 back up plan fails, participants may utilize an agency model attendant to provide emergency back up coverage. Service providers may provide emergency back up coverage in order to meet the immediate needs of the individual in a timely manner as well as ensure the health and welfare of the participant. The Care Manager is responsible during regular monitoring to validate that the strategies and back up plans are working and are still current. To assist in assuring the health and welfare of the individuals, participants are instructed to contact Care Manager to report disruptions of back up plans and strategies.

OLTL, in coordination with other state agencies and stakeholders, is currently enhancing the risk assessment and risk management protocols that are incorporated into service plan development. This is being developed as part of the Service Plan section of the work plan.

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

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

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

The Care Manager notifies the participant of the choice of the provider at the time of enrollment and at each reevaluation and offers to assist the individual in the selection process. Waiver participants may freely choose from any able and willing MA enrolled/certified provider. Participant/representatives are given a list of all qualified MA enrolled/certified providers from which to make their selection.

OLTL currently provides a toll-free complaint line for participants of other OLTL waivers and programs to report concerns about their provider. OLTL will enhance this toll-free complaint line and conduct outreach efforts to the Aging Waiver population to ensure that Aging Waiver participants have this additional resource for reporting concerns about their provider. Participants will be given the toll free number of the OLTL so they may contact OLTL regarding their choice of providers of the services in their ISP. This s is addressed in the attached work 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):

Process for Making Service Plan Subject to the Approval of the Medicaid Agency

The Care Manager facilitates the completion of the ISP by matching services to all identified needs in the assessment and then coordinates access to those services. The Care Manager is responsible for ongoing monitoring of the ISP to assure that the participant's needs are being met. The Care Manager, in conjunction with the participant or their representative, is responsible to modify the ISP if the participant's needs change.

When there is a change in the ISP, the Care Manager enters change in SAMS.

Currently, the OLTL service plan review process consists of a tiered review. The tiered review is based on the calculated cost of the service plan as follows.

\$0.00-\$55.00 per day are reviewed and authorized by the AAA.

\$55.01-\$90.00 per day are reviewed and authorized by the OLTL Regional Representative

\$90.01 and above reviewed and approved by the OLTL Service Plan Review Committee. The Service Plan Review Committee is a multidisciplinary team that includes nurses and social workers.

The purpose of the reviews is to increase consistency of the provision of care/services across the Commonwealth, maximize available resources to increase effectiveness of services provided and ensure the health and welfare of the participant. OLTL recognizes the need to improve the OLTL service plan review process. This process is being transitioned from a cost based tier structure to a function based structure that improves OLTL oversight and enhances participant-centered service plan development. This is being addressed as part of the attached work plan.

The OLTL completes annual reviews of each AAA. As part of that annual review, OLTL staff review a sampling of participant records, which include service plans.

## 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.

The Care Manager 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 to support participants make fully informed decisions
- Assists participants in gaining access to needed waiver services
- Works with and at the direction of the participant to identify, coordinate, and facilitate waiver 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 and telephone calls. A monthly contact in some form, either home visit or telephone, is required for all participants.
- Personal visits and telephone contacts may be done as frequently as needed and 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
- Is responsible during regular monitoring to validate that the strategies and back up plans are working and are still current. To assist in assuring the health and welfare of the individuals, participants are instructed to contact Care Manager to report disruptions of back up plans and strategies.

OLTL currently provides a toll-free complaint line for participants of other OLTL waivers and programs to report concerns about their provider. OLTL will enhance this toll-free complaint line and conduct outreach efforts to the Aging Waiver population to ensure that Aging Waiver participants have this additional resource for reporting concerns about their provider. This is addressed in the attached work plan.

**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:

A participant has the freedom of choice to receive their waiver services through the same provider or through different providers.

OLTL recognizes the need to strengthen the monitoring safeguards in this area. OLTL is developing a standardized form entitled the "Waiver Service Provider Choice Form" that all AAAs must present and explain to participants at the time of enrollment and at each subsequent annual reevaluation. Notation will be made in the participant's record to document receipt of the form. Completed forms will be maintained in the participants file at the AAA. OLTL will monitor receipt of the forms as part of annual reviews. This standard form and process is detailed in the attached work plan.

OLTL recognizes the need to update the OLTL service plan review and monitoring process in order to improve OLTL oversight and to ensure that AAAs are conducting ongoing plan monitoring that is free of conflicts of interest and in best interests of the participant. This is being addressed as part of the attached work plan.

OLTL currently provides a toll-free complaint line for participants of other OLTL waivers and programs to report concerns about their provider. OLTL will enhance this toll-free complaint line and conduct outreach efforts to the Aging Waiver population to ensure that Aging Waiver participants have this additional resource for reporting concerns about their provider. This is addressed in the attached work plan.

The OLTL will complete annual reviews of each AAA. As part of that annual review, OLTL staff review a sampling of participant records, which include service plans. OLTL is further enhancing monitoring safeguards as part of the attached work plan.

**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**

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

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

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

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Survey Data**

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

**Data Aggregation and Analysis:**

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

	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
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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):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

Data Source (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%+/-5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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**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( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative Data**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

	Specify: <input style="width: 100%;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Administrative Data**

Responsible Party for data	Frequency of data	Sampling Approach (check

<b>collection/generation</b> (check each that applies):	<b>collection/generation</b> (check each that applies):	<i>each that applies</i> :
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = 95%+/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

- 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 Aging Waiver participant's annual review date.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

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

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

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

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = 95%+/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = 95%+/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

- 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):

**Other**

If 'Other' is selected, specify:

**Administrative Data**

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Number and percent of received 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval =
		<input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 100% of received surveys
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

- 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):

**Other**

If 'Other' is selected, specify:

**Record Review**

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**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):

Other

If 'Other' is selected, specify:

**Record Review**

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

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

- 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 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)**

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

**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 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 E: Participant Direction of Services

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

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

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

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

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

**Yes. The State requests that this waiver be considered for Independence Plus designation.**

**No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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### E-1: Overview (1 of 13)

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

Self-Directed Opportunities Available with the Aging Waiver

The Aging Waiver offers self-direction under the Personal Assistance Services (PAS). PAS is available statewide and offers participants employer authority. More specifically, participants have the option to recruit, interview, hire, manage and dismiss personal assistance workers. Participants serve as the common law employer and use a Fiscal/Employer Agent (offered under Financial Management Services – FMS) to serve as his or her agent to perform payroll and employment tasks.

#### How Participants May Take Advantage of Self-Directed Opportunities

Participants may choose to self-direct during the initial assessment process, at reassessment, or at any time. The Care Manager discusses all available service options and ensures each participant understands the full range of opportunities with the waiver.

#### Entities That Support Individuals:

Individuals will receive support from certified Fiscal/Employer Agents and Care Managers 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 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 Care Manager

In addition, individuals choosing the Consumer Employer Model will receive assistance from Care Manager 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 Care Manager will:

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

## Appendix E: Participant Direction of Services

### 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.

At the time of application and/or at the point in the eligibility and assessment process the individual is found to be eligible for Aging Waiver services, the Care Manager informs the participant of the opportunity for participant directed services through the Consumer Employer Model. The Care Manager informs the participant that the Consumer Employer Model can be used for personal assistance services in the waiver.

The Consumer Employer Model provides the participant the right to hire, fire, schedule, and supervise individuals providing their Personal Assistance Services. The Financial Management Services (FMS) Fiscal Employer/Agent (FE/A) performs the fiscal agent tasks of payroll generation and related tax filings for the Consumer Employer Model. The FE/A informs the participant that training will be provided to assist them in these areas. The FE/A 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 will be developing consistent materials to inform current and prospective waiver participants about the benefits and potential liabilities of participant-direction. Participant materials will include a comprehensive participant reference manual which will contain details about participant-direction roles, responsibilities, and informed decision-making. More information about this activity can be found in the attached work plan.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: *(check each that applies)*:

- Waiver services may be directed by a legal representative of the participant.**
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver services may be directed by a non-legal representative freely chosen by an adult participant. 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:

A personal representative will be required for any individual who has impaired judgment as identified on the LOCA and/or is unable to:

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

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

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

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Personal Assistance Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Transportation	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- Governmental entities**
- Private entities**

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not*

complete Item E-1-i.

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- FMS are covered as the waiver service specified in Appendix C1/C3**

**The waiver service entitled:  
Financial Management Services**

- 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:

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

*Specify:*

- Enroll participants in FMS and apply for and receive 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 Care Manager participant and the Care Manager

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Supports furnished when the participant exercises budget authority:

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

- Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- Other services and supports

Specify:

Additional functions/activities:

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

Specify:

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The 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
Respite	<input type="checkbox"/>
Companion Services	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Personal Emergency Response Service (PERS)	<input type="checkbox"/>
Personal Assistance Services	

	<input type="checkbox"/>
<b>Financial Management Services (FMS)</b>	<input type="checkbox"/>
<b>Adult Daily Living Services</b>	<input type="checkbox"/>
<b>Home Delivered Meals</b>	<input type="checkbox"/>
<b>Home Support</b>	<input type="checkbox"/>
<b>Transportation</b>	<input type="checkbox"/>
<b>Personal Care</b>	<input type="checkbox"/>
<b>TeleCare</b>	<input type="checkbox"/>
<b>Community Transition Services</b>	<input type="checkbox"/>
<b>Environmental Modifications</b>	<input type="checkbox"/>
<b>Counseling</b>	<input type="checkbox"/>
<b>Home Health Care</b>	<input type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

#### Entities That Furnish These Supports:

The existing Case Management structure at the Area Agencies on Aging will be use to support individuals who choose to self-direct. The local AAA will recruit individuals who hold a strong belief in the philosophy of participant-direction and embrace the self-directed models.

#### How Supports are Compensated:

The Area Agencies on Aging provide Case Management to waiver participants as an administrative activity. The DPW compensates the local AAAs for providing Case Management to all waiver participants. The AAA bills the Department on a monthly basis for actual costs of providing Case Management not to exceed the established per member monthly rate.

#### Supports Furnished to Participants Choosing self direction:

Individuals choosing to self-direct will receive support from a Care Manager. This activity includes an array of support activities to ensure the participant is successful with the participant-directed approach. Responsibilities of the Care Manager include:

- Assist the participant to gain information and access to necessary services, regardless of the funding source of the services.
- Assist the participant to develop an individualized back-up plan.
- Assist the participant to identify risks and develop a plan to monitor those risks.
- Provide participants with information regarding self direction on an ongoing basis, including information about rights, responsibilities and the liabilities of self-direction.
- Monitor the provision of the services to ensure health and welfare.
- Work with the participant as necessary to ensure all employment paperwork is completed and sent to the F/EA.
- Instruct and guide the participant in problem solving, decision-making, and recognizing and reporting critical events.
- 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
- Identify and report critical incidents, abuse, neglect or exploitation.

#### Methods and frequency of assessing the performance of the entities that furnish these supports:

Each provider must be reviewed and approved annually by the OLTL. The purpose of the annual review is to ensure that the provider continues to meet standards and that the highest quality services are provided to each participant. Only providers who are annually reviewed and approved by the OLTL may continue to participate in the waiver/program. The basis upon which a provider is and remains approved to provide services include:

- Verification of the provider's qualifications;
- Results of an initial FMS certification review conducted by the OLTL within six (6) months from the date a new Government or Vendor F/EA begins serving participants;
- Satisfactorily addressing all elements of any plan of correction that is prepared as a result of an initial FMS certification review conducted by the OLTL;
- Results of annual recertification review conducted by OLTL;

- Satisfactorily addressing all elements of any plan of correction that is prepared as a result of an annual recertification review conducted by the OLTL;
- Results of any unannounced monitoring visits, as deemed necessary; and
- Verbal and written feedback from participants on the quality of services rendered.

The review methods that the OLTL will use during the initial FMS certification review and annual recertification review process include:

- Conducting Government or Vendor F/EA certification and recertification reviews onsite at the Government or Vendor F/EA's site using OLTL's FMS certification/recertification review protocol, which includes the standards included in this document;
- Issuing plans of correction to Government or Vendor F/EA based on the findings of the applicable FMS certification/recertification reviews;
- Reviewing Government or Vendor F/EA's response to any plans of correction as a result of a FMS certification or recertification review and determining if the Government or Vendor F/EA has successfully addressed the items included in the plan, which includes the standards included in this document;
- Conducting any unannounced monitoring visits, as deemed necessary;
- Reviewing verbal and written feedback from participants on the quality of FMS rendered;
- Determining the extent to which the Government or Vendor F/EA has modified or is willing to modify the delivery of FMS based on feedback from participants; and
- Reviewing the Government or Vendor F/EA's records to ensure that their contents support the amounts claimed on the FMS provider claims form, CMS-1500 and that sufficient and current participant and service information is available.

The Government and Vendor F/EA establishes and maintains current and archived files and documentation for participants, representatives, direct care workers, direct service providers and vendors including independent contractors and themselves and their subagent or reporting agent, as appropriate in a confidential and secure manner and for the time period required by 45 CFR § 92.42, applicable federal, state and local agencies.

## 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 a participant direction model to another service delivery model by contacting their Care Manager who will guide them through the process of transition. When a participant voluntarily chooses to terminate participant direction, they will notify their Care Manager. The Care Manager will ensure that there is not a break in service during the transition period.

## 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 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 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 Consumer Employer Model would occur only after a team meeting with the participant, the participant’s Care Manager, and any family, friends and advocate if requested by the participant and a review of the recommendations by the OLTL.

The Care Manager 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.

**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	5778	
Year 2	6495	
Year 3	7239	
Year 4 (renewal only)	8012	
Year 5 (renewal only)	8061	

**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:

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

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

- Recruit staff**

- Refer staff to agency for hiring (co-employer)
- Select staff from worker registry
- Hire staff common law employer
- Verify staff qualifications
- Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

To ensure all participants make informed choice of service and service delivery, criminal background checks are mandatory for individuals performing personal assistance services, hired after July 1, 2008. Participants using the 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.

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

Specify:

## Appendix E: Participant Direction of Services

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

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

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

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

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

Specify:

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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

- 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.

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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

- 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.

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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

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

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

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

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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


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

## Appendix F: Participant Rights

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### 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 Area Agency on Aging. The AAA 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 AAA'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."

Participants are informed by the AAA that they may appeal an adverse action taken by the AAA within 30 days of notification. The participant may file an appeal through a letter to the Secretary of Aging.

The AAA issues a "Notification of Adverse Actions and the Right to Appeal" form to inform the participant of their right to a fair hearing. The AAA must send a written notice to the individual when services are denied, reduced, or terminated. The notice also indicates that there will be no disruption of services pending an appeal. The AAA retains copies of written notices at the local agency level.

Within two business of the request for Fair Hearing, a AAA must forward a copy of the request to the DPW Bureau of Hearings and Appeals (BHA).

The individual may then try to resolve an issue through a fair hearing conducted by the Bureau of Hearings and Appeals (BHA). Title 55 PA Code §275.4(a)(2) states that individuals must file an appeal with the agency that made the determination being questioned, and §275.1(a)(3) specifically includes social service agencies: "the term Department includes, in addition to County Assistance Offices, agencies which administer or provide social services under contractual agreement with the Department." This includes the AAAs. The AAA is 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)].

The AAA 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 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.

The Fair Hearings process will be coordinated with current complaint and incident reporting processes. This will be one mechanism for reviewing existing structures to determine issues in need of resolution, including timing and applicability. Fair hearings and appeals will be further addressed as a component of the work plan.

## 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 grievance or complaint is first registered with the Local AAA. If the grievance or complaint is unresolved or regarding the AAA it will be referred to OLTL.

Grievance/complaint system operations will be addressed further as part of the Quality Strategy work plan.

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

The OLTL operates a toll free hotline. 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.

Waiver participants have the opportunity to identify and seek resolution of all problems and issues related to the services they receive and or accessing services they have been authorized to receive.

The AAA notifies the participant that they may contact their care manager to clarify and discuss any problems or issues. The AAA also notifies the participant that they may contact their care manager's supervisor or the AAA Director if they are dissatisfied with the outcome. Participants may also contact OLTL through the toll free hotline or regional staff.

Upon receipt of the complaint an investigation is initiated within 2 business days.

Resolution of grievances and complaints is accomplished through investigation and contact with the local Area Agency on Aging, the participant, the provider, or any other identified parties utilizing record review, interview and observations. A summary of the investigation is documented and the complainant receives a written response. Participant that elects to make a complaint is informed that the complaint is not a pre-requisite or substitute for a fair hearing. When a complaint is received and the participant has filed an appeal the participant is encouraged to continue with the appeal process.

Grievance/complaint system operations will be addressed further as part of the Quality Strategy work plan.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)

**No. This Appendix does not apply** (do not complete Items b through e)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In Pennsylvania, the Older Adult Protective Service Act has set forth the following specific definitions of abuse, neglect, exploitation and abandonment, and are defined as follow:

Abuse is defined as the occurrence of one or more of the following acts:

- The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish;
- The willful deprivation by a caregiver of goods or services, which are necessary to maintain physical or mental health;
- Sexual harassment, rape or abuse, as defined in the Protection From Abuse Act (23 Pa. C.S.A., Sections 6101-6117).

Neglect is defined as the failure to provide for oneself or the failure of a caregiver to provide goods or services essential to avoid a clear and serious threat to physical or mental health.

Exploitation is defined as an act or course of conduct by a caregiver or other person against an older adult or an older adult's resources, without the informed consent of the older adult or with consent obtained through misrepresentation, coercion or threats of force, that results in monetary, personal or other benefit, gain or profit for the perpetrator or monetary or personal loss to the older adult. The data reveals that financial exploitation ranks closely above physical abuse.

Abandonment is defined as the desertion of an older adult by a caregiver. Abandonment continues to account for less than one percent of the reports received.

Any person who reasonably believes that an older adult is being abused, neglected, exploited or abandoned can file a report with the local area agency on aging. Reports may be filed via the phone or in written form. Individuals reporting voluntarily may choose to remain anonymous and still be assured that their report will be investigated. An administrator or employees of a Nursing Facility (NF), Personal Care Home (PCH), Domiciliary Care home, adult day care facility or home health care agency must immediately report suspected allegations of abuse to the local Area Agency on Aging (AAA). Within 48 hours they must make a written report to the agency. Each AAA must have a toll-free telephone number available in order to report abuse 24 hours a day, 365 days a year. A report can be filed on behalf of an older adult whether the person lives in the community or in a state-licensed facility such as a nursing home, personal care home or hospital.

Within 48 hours of receipt of a written report under § 15.152 (relating to additional reporting requirements) involving sexual abuse, serious physical injury, serious bodily injury or suspicious death, the AAA shall transmit a written report to the Department of Aging.

Additionally, the Office of Long Term Living maintains a statewide toll free number that has been widely publicized to program participants, providers, legal representatives and family members.

Further refinement of the critical event or incident reporting system is included as part of the work plan.

- 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.

The participant is informed, by the Care Manager; of the availability of protective services at the time of enrollment and

reevaluation. This includes the availability of the AAA's toll free number and the process for reporting. This information is reviewed with the participant if there is suspicion of abuse, neglect, exploitation or abandonment.

The law and regulations address the importance of ongoing protective services education and training. The strategy for education and training provides for training of three distinct populations. These populations are local protective services staff, practitioners/other professionals who come into regular contact with older adults and the general public, and are defined as follows:

**Protective Services Staff** - must undergo a criminal history background check. All caseworker, supervisory or intake worker training as set forth in the protective services regulations (6 Pa. Code §15.121) must be completed by protective services employees. The commonwealth provides a minimum of six regularly scheduled trainings each year to protective services supervisors and caseworkers on investigative techniques and casework skills.

**Practitioners/Other Professionals** - Since the beginning of the program, the commonwealth has undertaken various activities to educate practitioners/other professional groups having frequent contact with older adults. The educational activities have been designed to maximize the ability to recognize the symptoms of abuse, neglect, exploitation and abandonment so that accurate reporting of the potential need for protective services can occur. Educational materials have been created for professionals such as emergency room physicians, home health care providers, law enforcement officers, domestic violence workers, victim services workers and sexual abuse workers.

**General Public** - Activities concerning the statewide public education and information campaign have included development of programs and public service announcements for television, radio and newspapers; pamphlets, posters, information posted on the Department's website, and participation at local and statewide conferences.

This ongoing campaign shall utilize materials and methodology developed by the Department and supplemented by the area agency with relevant information on the local protective services system. Special emphasis shall be placed on informing the community on how to make reports and request services.

- 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.

Allegations are reported to AAAs. After an allegation is reported to an AAA, the allegations are investigated to determine if the older person needs protective services. If protective services are needed, a comprehensive client needs assessment is conducted and protective services are offered.

#### Investigations

Every report that a AAA receives must be investigated to determine if the allegation is substantiated or unsubstantiated. Investigations can be conducted only by protective services workers who have received training in investigative practices and procedures. Every report received by the AAA is classified either as an emergency, a priority, or a non-priority case. The investigation of an emergency case must begin immediately; a priority case within 24 hours; and a non-priority case within 72 hours. If the investigation substantiates that the older person needs protective services, an assessment must be completed and protective services must be offered. The older person has the right to refuse services.

The report of need is an intake form completed by a trained individual to include sufficient information so that the intake worker, and subsequently the protective service worker, can identify and report the service category assigned to each case. Reportable major and serious incidents or critical events include: any allegation of domestic violence, abuse, neglect, exploitation, misconduct by any provider or their representative or misconduct by a participant. Reporting requirements cover all waiver participants including those who self-direct.

Trained staff from AAA classify reports into one of five (5) categories: emergency, priority, non-priority, another planning and service area, and no need for protective services. This categorization determines the timetable for beginning the investigation.

#### Emergency -- Immediate response

An emergency case requires immediate attention due to the possibility of imminent risk of death or serious physical harm to the older person. These reports are immediately referred to a protective services caseworker. The investigation of an emergency report is initiated immediately following the referral. The investigator makes every attempt to ensure the immediate safety of the older adult and to immediately conduct a face-to-face visit.

#### Priority – Response within 24 hours

A priority case is one in which the need for protective services is serious enough to require early, but not immediate intervention. The person receiving a priority report immediately refers it to a protective services caseworker. The investigation of a priority report is initiated as soon as possible. Reasonable attempts are made to initiate the investigation within 24 hours after the report is received.

#### Non-priority – Response within 72 hours

A non-priority case does not require immediate or early intervention by the agency. Reports in this category are referred to a protective services caseworker within the normal hours of the agency's current or next day of business. The investigation of a non-priority report is initiated in a timely manner but never later than 72 hours after the report is received.

#### Another Planning and Service Area (PSA)

A case placed in this category is one in which the older person reported to need protective services is located in another Planning and Service Area (PSA) at the time of the report. A report in this category also meets the criteria for placement in the emergency, priority or non-priority category and is referred to the PSA where the victim is located in accordance with those categorical requirements.

#### No Need for Protective Services

A report is placed in this category when the person reported to be in need of protective services meets one or more of the following criteria:

a person within the jurisdiction of the Commonwealth who is not 60 years of age or older (PDA has no authority, under OAPSA, to investigate reports concerning adult consumers under 60);

has the capacity to perform or obtain without help the services necessary to maintain physical or mental health; or

has a responsible caretaker; or has no imminent risk to his/her person or property.

This type of report is referred to a protective services caseworker during the normal hours of the current or next day of business. The protective services caseworker reviews the details of the report and confirms or rejects the categorization. If the caseworker confirms the screening categorization, appropriate referrals are made to the AAA case management system. Adults under 60 years of age are referred to an appropriate agency. If the caseworker rejects the categorization, the report is placed in the appropriate category and handled accordingly.

#### Unsubstantiated Reports

A case opened by an unsubstantiated report shall be closed and information identifying the person, who made the report and the alleged perpetrator of abuse, if applicable, shall be immediately deleted from the case record.

For the purposes of substantiating a pattern of abuse, neglect, exploitation or abandonment, the name of the person reported to need protective services and other information relevant to the circumstances which led to the report may be maintained for 6 months in a separate locked file accessible only to limited authorized staff for review when it is necessary to establish that a previous report was made. At the end of 6 months, case records maintained under this subsection shall be destroyed unless additional reports lead to their being reopened.

#### Substantiated Reports

The AAA shall provide for a timely assessment of the need for protective services by the older adult who is the subject of a substantiated report if the older adult gives informed consent to an assessment. If an older adult found to need protective services does not consent to an assessment, the agency may seek, when appropriate, a court order under § 15.61.

On the basis of the assessment, the AAA shall provide for the development of a service plan of recommended actions which reflect the least restrictive alternatives for removing or reducing imminent risk to person or property and promote self-determination and continuity of care being provided at the time of the agency's intervention. The service plan may include, when appropriate, the pursuit of civil or criminal remedies.

The AAA shall discreetly notify the older adult during the investigation that a report of need for protective services has been made and shall provide the older adult with a brief summary of the nature of the report. The protective services caseworker performing the investigation shall determine when and how this notification is accomplished.

The AAA shall notify the alleged perpetrator at the conclusion of the investigation of the report that allegations have been made and shall provide the alleged perpetrator with a brief summary of the allegations.

Further refinement of the critical event or incident reporting system is included as part of the work plan.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Agencies responsible for oversight include: the Department of Aging, the Office on Long Term Living and the Department of Health.

Under the Aging Waiver, Care Managers are required to periodically visit and assess participants. If an instance of abuse, neglect or exploitation is found, the Care Manager will immediately refer the case to the local protective services unit. The Department of Aging also continues to conduct systematic monitoring and evaluation of the quality of protective services provided by the AAAs while providing the administrative and clinical technical assistance needed to maintain program and service quality. The Department of Aging has expanded its Consumer Protection Division, and enhanced the quality oversight for all local programs. The Consumer Protection Division, under the Bureau for Advocacy, Protection and Education, is responsible for monitoring and conducting two yearly on-site reviews of protective services programs, and providing ongoing technical assistance to the local

agencies.

The Department of Aging maintains a statewide database on all participants who were referred to the Protective Service Unit for investigation of allegations of abuse, neglect, exploitation and abandonment. The Office of Long Term Living will have access to this database. Information is highly confidential but can be accessed by specified PDA and State Medicaid agency staff.

Refinement of to the oversight of critical incidents and events will be addressed in the work plan.

## Appendix G: Participant Safeguards

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

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

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

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

During enrollment and at reevaluation the AAA reviews the process for reporting the use of Restraints and Restrictive Interventions with the participant which includes reporting it to the Care Manager. The Care Manager 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 Care Managers 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 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 AAA 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:

During enrollment and at reevaluation the AAA reviews the process for reporting the use of Restraints and Restrictive Interventions with the participant which includes reporting it to the Care Manager. The Care Manager 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 of restrictive interventions through the Care Managers 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 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 AAA 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.

Only participants who require respite services with a Nursing Facility, the Nursing Facility regulations apply. Nursing Facilities are licensed and inspected by the PA Department of Health (DOH). Bureau of Facility Licensure and Certification and are subject to the Nursing Home Regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1-483.75.

- 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.

Nursing Facilities are licensed and inspected by the PA DOH Health, Bureau of Facility Licensure and Certification and are subject to the Nursing Home regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1 – 483.75. DOH performs yearly surveys and medication management is part of the survey. Nursing facilities pharmacy management is governed under the following authority 28 pa code § 211.9 amended under section 803 of the Health Care Facilities Act (35 P. S. § 448.803); and section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)).

## Appendix G: Participant Safeguards

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

**c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications. *Select one:***

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Only participants who require respite services within a Nursing Facility, the Nursing Facility regulations apply. Nursing Facilities are licensed and inspected by the PA Department of Health (DOH), Bureau of Facility Licensure and Certification and are subject to the Nursing Home regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1 – 483.75. Department of Health Regulations for Nursing Facilities can be located at the DOH web site at <http://www.dsf.health.state.pa.us/health/site/default.asp>: scroll down page and click on Nursing facilities, then click Long term care licensure regulation.

**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:

PA Department of Health  
Department of Public Welfare

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

All identified medication errors are required to be recorded.

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

The Aging Waiver provides services to participants in their own personal residences or in the home of a family member. In the event that a participant requires respite services in a Nursing Facility, the Nursing Facility regulations apply. Nursing Facilities are licensed and inspected by the PA Department of Health, Bureau of Facility Licensure and Certification and are subject to the Nursing Home regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1 – 483.75.

- 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.

Only participants who require respite services within a Nursing Facility, the Nursing Facility regulations apply. Nursing Facilities are licensed and inspected by the PA Department of Health (DOH), Bureau of Facility Licensure and Certification and are subject to the Nursing Home regulations of Title 28 and 55 of the PA Code and 42 CFR 483.1 – 483.75. Department of Health Regulations for Nursing Facilities can be located at the DOH web site at <http://www.dsf.health.state.pa.us/health/site/default.asp>: scroll down page and click on Nursing facilities, then click Long term care licensure regulation.

## 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**

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

**Data Aggregation and Analysis:**

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

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

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

**Data Aggregation and Analysis:**

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

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

**Data Aggregation and Analysis:**

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

**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( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

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

**Data Aggregation and Analysis:**

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

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

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

**Data Aggregation and Analysis:**

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

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

	Specify: <input type="text"/>	
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**Data Aggregation and Analysis:**

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

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

**Data Aggregation and Analysis:**

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

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

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

**Data Aggregation and Analysis:**

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

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

**Data Aggregation and Analysis:**

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

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

**Data Aggregation and Analysis:**

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

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

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

- 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 Quality Improvement Section.

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 complaint 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 Care Manager supervisor regarding the need to provide appropriate information to the waiver participant. The Care Manager 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 Care Manager supervisor is then responsible for providing the written verification to BIS.

**ii. Remediation Data Aggregation**

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

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

**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 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 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**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Quality Improvement Committee</b>	<input type="checkbox"/> <b>Annually</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**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 methods used to ensure the integrity of payments made for waiver services include:

(a) An annual fiscal year audit of state government and providers of services conducted in compliance with the requirements of the Single Audit Act of 1984, P.L. 98-502, and the Single Audit Act Amendments of 1996, P.L. 104-156. Pennsylvania's 4300 regulations require that all subrecipients (profit and nonprofit) have an annual audit conducted in accordance with Generally Accepted Governmental Auditing Standards (GAGAS). If the subrecipient is a nonprofit and meets the thresholds, a Single Audit is required. If the subrecipient is a for-profit entity expending \$500,000 or more in federal Department of Health and Human Services funding, the entity has the option to either have an annual Single Audit or a program specific audit conducted in accordance with GAGAS.

(b) The Department of the Auditor General, an independent office, and the fiscal "watchdog" of Pennsylvania taxpayers conducts the annual state fiscal year, Commonwealth of Pennsylvania Single Audit. The Office of Management and Budget (OMB) Circular No. A-133 issued pursuant to the Single Audit Act as amended, sets forth standards for obtaining consistency and uniformity for the audit of States, local governments, and non-profit organizations expending Federal awards. Additionally, the A-133 Compliance Supplement based on the requirements of the 1996 Amendments and 1997 revisions to OMB Circular A-133 provides for the issuance of a compliance supplement to assist auditors in performing the required audits. The guidelines presented in the compliance supplement are the basis for the financial and compliance testing of waiver services.

(c) Recipients of Federal funds who are contracted directly through the State or are enrolled as MA providers of service are audited annually in accordance with the Single Audit Act, as amended. Profit and non-profit providers of service are audited exclusively by contracting with CPA firms. The Department of Public Welfare (DPW) releases an annual Single Audit Supplement publication to county government and CPA firms which 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 providers of service regardless of whether the provider is a public or a private organization.

(d) The purpose of the Single Audit Supplement is to fill four basic needs: 1) a reference manual detailing additional financial and compliance requirements pertaining to specific DPW programs operated by local governments and/or private agencies; 2) 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 the DPW; 3) a vehicle for passing compliance requirements to a lower tier agency; 4) additional guidance to be used in conjunction with Single Audit as amended, OMB Circular A-133, Government Auditing Standards (commonly know 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.

(e) 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 reports and conducts onsite reviews of services rendered through review of time sheets where applicable, services rendered reports and participant interviews.

Depending on the findings of reviews, remediation may require:

- OLTL monitoring and training of provider staff in documentation of services rendered
- Time-limited monitoring by Care Manager or Care Manager Supervisor of weekly time sheets submitted by staff
- Suspension of new provider enrollment
- Termination of waiver provider agreement
- Requiring the provider to refund inappropriately billed amounts

If issues of fraud and abuse are found, OLTL through the DPW Office of General Counsel (OGC) will refer such situations to the DPW Office of Medical Assistance Programs (OMAP) Bureau of Program Integrity for review, investigation and necessary action.

Enhancements to financial oversight are included as part of the work plan submitted with the waiver.

## 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**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/-5%

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

**Data Aggregation and Analysis:**

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

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% +/-5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b>	

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

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

- 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 a report reveals a claim that is overpaid in accordance with the rate methodology, OLTL/ Financial Bureau would initiate steps to recoup the overpayment.

If providers submit claims for services not covered by the waiver and are paid for those services with waiver funds, Bureau of Provider Supports 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 OLTL. 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 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.

**ii. Remediation Data Aggregation**

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

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

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

**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 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.

**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).

OLTL has established the following requirements with regard to rate setting for the Aging Waiver program.

- The current Medical Assistance fee schedule must be utilized for the following services: Nursing Facility respite, transition services, non-emergency transportation, specialized medical equipment and supplies and home health services.
- PAS, the ceiling rate is established and published by the Office of Long Term Living in the Medicaid Agency
- For services other than those listed above, the AAA must establish a ceiling rate based on competitive procurement as defined under Aging Program Directive #05-01-07, PDA Contract Procurement Requirements for AAA. The rates are established in PDA's data base and reviewed and accepted by PDA staff on an annual basis. Promise reimburses qualified providers/agencies through the HCSIS interface.

The Department issued Aging Program Directive #05-01-07 which can be located on the Department of Aging website at: <http://www.aging.state.pa.us>;

Information regarding payment rates is made available to all waiver participants during the service planning process.

In accordance with guidance provided by the Centers for Medicare and Medicaid Services (CMS), the State Medicaid Agency has established a goal to achieve a level of standardization in the rate methodology that uses sound principles, assumptions and data inputs. The resulting provider fees/rates will thus be based on a standardized platform with variation in rates driven by specific, objective criteria such as geography or intensity. To assist in the development of a rate methodology, the SMA has contracted with a consultant. To develop its proposed methodology and work plan, the SMA recognizes the importance of the following objectives in achieving success and stakeholder support for change:

**Engage stakeholders**

Gather and effectively use available data such as provider cost information, historical fee-for-service (FFS) data on waiver services, and experience from other state Medicaid programs to support the rate development methodology

Evaluate the larger impact of the updated rate methodology from the Commonwealth's, provider's and consumer's perspective

Allow enough time to review the output of the rate methodology with program stakeholders, answer questions and ensure acceptance of the new methodology.

OLTL is in the process of revising its rate setting methodology as part of a DPW-wide rate standardization effort setting. Methodologies, policies and procedures for rate determination will be developed further as part of the work plan.

- 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:

Service plan information is managed in the SAMS System. Changes that are made to service plan information in SAMS are transferred to HCSIS (Home and Community Services information System) on a daily basis through a nightly upload.

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 Aging Waiver.

Once the service is delivered the MA enrolled provider bills the PROMISE system for services rendered to the Participant, the

following process occurs:

When claims are made by qualified enrolled MA providers into PROMISe system, PROMISe system will check the Consumer Information System (CIS) for Medicaid eligibility and Aging Waiver eligibility and the provider is MA enrolled in good standing.

PROMISe then will check the information that is stored in HCSIS to verify the necessary information (verifies provider, units, service on the service plan) on the participants service plan before approving the claim for payment. If services are not on the HCSIS service plan the claim is then denied.

- 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.*

Area Agencies on Aging provide Community Transition Services. Additionally, 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. OHCDs enrollment will be voluntary and require member agencies to sign an agreement with OLTL. Provider may choice to enroll as Medical Assistance Providers and bill the state directly. Personal Emergency Response (PERS), Transportation, Specialized Medical Equipment, Environmental Modifications 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:*

- 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:

Services will be provided to eligible waiver participants throughout the Commonwealth. Each individual enrollee receives services in accordance with his/her individualized service plan based upon the assessed needs. The state share of payments for services a provided under the waiver is made entirely from state funds appropriated by the Pennsylvania General Assembly. Some of these state funds are derived from IGT funds transferred to the Commonwealth by certain county governments. The matching arrangement that generates the IGT is fully described in Office of Inspector General report A-03-00-00211 and Pennsylvania's response thereto. The remainder of the state funds is derived from the tobacco litigation settlement proceeds and other general revenue sources. The state does not use provider tax revenues to fund the state share of payments for waiver services.

**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:

Some of the state funds are derived from IGT funds transferred to the Commonwealth by certain county governments. The matching arrangement that generates the IGT is fully described in Office of Inspector General report A-03-00-00211 and Pennsylvania's response thereto.

**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:

Pursuant to 42 CFR 441.310 (a) (2), the Department will only reimburse service providers for room and board costs when respite services are provided in Medicaid Certified Hospitals and Nursing Facilities.

Reimbursement for room and board costs when respite services are provided in private residences are excluded under the Aging Waiver.

The PROMISe MMIS system completes an authorization of individual's eligibility for services within the waiver. Waiver services, other than per diem respite, cannot be billed when an individual is in a facility.

Single Audit protocols include review for the room and board exclusion.

## 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	15112.61	2281.00	17393.61	51852.00	7259.28	59111.28	41717.67
2	15826.38	2596.00	18422.38	52884.00	7404.76	60288.76	41866.38
3	16126.10	2927.00	19053.10	53340.00	7467.60	60807.60	41754.50
4	16404.56	3264.00	19668.56	55020.00	7702.80	62722.80	43054.24
5	16491.01	3349.00	19840.01	56124.00	7857.36	63981.36	44141.35

**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	28481		28481
Year 2	31350		31350
Year 3	34325		34325
Year 4 (renewal only)	37420		37420
Year 5 (renewal only)	37615		37615

**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 based on history of 372 reports.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (3 of 9)**

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Based on actual history of utilization and establishing a percentage each service is utilized compared to all services. The number of participants is projected from history and average participants entering the waiver and average participants leaving the waiver. The rates are adjusted for cost of living increases for services.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The D' factor is obtained the same way as the D factor. The entire database of waiver participants is available. Each participant's non-waiver MA costs are identified, including the deduction of Medicare Part D drug costs.

- 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:

The G factor was formulated based on actual data received from the Department of Public Welfare's Office of Budget – Medical Assistance Section. Actual numbers of nursing facility participants served as well as money spent is tracked on an annual basis.

- 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:

G' is obtained from the Department of Public Welfare's Office of Budget. The Medical Assistance Section annually gathers this data for all individuals who received MA to pay for their nursing facility services, including the deduction of Medicare Part D drug costs.

## 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
Respite
Companion Services
Specialized Medical Equipment and Supplies
Personal Emergency Response Service (PERS)
Personal Assistance Services
Financial Management Services (FMS)
Adult Daily Living Services
Home Delivered Meals
Home Support
Transportation
Personal Care
TeleCare
Community Transition Services
Environmental Modifications
Counseling
Home Health Care

## 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
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<b>Respite Total:</b>						3962172.00
Respite In Home	15 Min	360	721.00	5.10	1323756.00	
Respite In Home Shift	Shift	99	36.00	214.00	762696.00	
Respite LTC Facility	Per Diem	539	20.00	174.00	1875720.00	
<b>Companion Services Total:</b>						4287486.14
Companion Services	15 Min	1042	1367.00	3.01	4287486.14	
<b>Specialized Medical Equipment and Supplies Total:</b>						7346323.50
Specialized Medical Equipment and Supplies	Per Purchase	8149	6.00	150.25	7346323.50	
<b>Personal Emergency Response Service (PERS) Total:</b>						2834400.00
Personal Emergency Response Service (PERS)	Monthly Monitoring	11810	8.00	30.00	2834400.00	
<b>Personal Assistance Services Total:</b>						155966025.45
Agency	15 Min	1236	4550.00	4.68	26319384.00	
Consumer	15 Min	6791	4645.00	4.11	129646641.45	
<b>Financial Management Services (FMS) Total:</b>						4583925.00
Financial Management Services (FMS)	Monthly	6791	9.00	75.00	4583925.00	
<b>Adult Daily Living Services Total:</b>						17572621.92
Adult Daily Living Full Day	Full Day	3014	92.00	62.14	17230676.32	
Adult Daily Living Half Day	Half Day	115	92.00	32.32	341945.60	
<b>Home Delivered Meals Total:</b>						8584025.20
Meal	Meal	6644	145.00	6.29	6059660.20	
Sandwich	Sandwich	5420	135.00	3.45	2524365.00	
<b>Home Support Total:</b>						8167686.80
Home Support	15 Min	3656	455.00	4.91	8167686.80	
<b>Transportation Total:</b>						3699656.25
Transportation	One Way Ride	3875	95.00	10.05	3699656.25	
<b>Personal Care Total:</b>						202105980.88
Personal Care	15 Min	19739	1978.00	5.14	200684833.88	
Personal Care Shift	Shift	92	485.00	31.85	1421147.00	
<b>TeleCare Total:</b>						1478320.00
Health Status Measuring and Monitoring Purchase	Per Purchase	200	28.00	164.00	918400.00	
Health Status Measuring and Monitoring Per Diem	Daily	200	136.00	10.00	272000.00	
Activity and Sensor Monitoring Purchase	Purchase	200	2.00	200.00	80000.00	
Activity and Sensor Monitoring Monthly	Monthly	200	8.00	79.95	127920.00	
Medication Dispensing and Monitoring	Monthly	200	8.00	50.00	80000.00	

<b>Community Transition Services Total:</b>						1212005.48
Community Transition Services	One Time Purchase	476	1.00	2546.23	1212005.48	
<b>Environmental Modifications Total:</b>						2917563.09
Environmental Modifications	Per Purchase	1261	3.00	771.23	2917563.09	
<b>Counseling Total:</b>						1162069.44
Counseling	Per Visit	609	16.00	119.26	1162069.44	
<b>Home Health Care Total:</b>						4541988.43
Home Health Aide	Per Visit	147	175.00	40.73	1047779.25	
Nursing	Per Visit	1652	26.00	66.25	2845570.00	
Physical Therapy	Per Visti	324	18.00	78.18	455945.76	
Occupational Therapy	Per Visit	123	19.00	78.46	183361.02	
Speech Therapy	Per Visit	10	12.00	77.77	9332.40	
<b>GRAND TOTAL:</b>						430422249.58
Total Estimated Unduplicated Participants:						28481
Factor D (Divide total by number of participants):						15112.61
Average Length of Stay on the Waiver:						279

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Respite Total:</b>						4882130.32
Respite In Home	15 Min	403	793.00	5.20	1661810.80	
Respite In Home Shift	Shift	111	40.00	218.28	969163.20	
Respite LTC Facility	Per Diem	604	21.00	177.48	2251156.32	
<b>Companion Services Total:</b>						5388365.76
Companion Services	15 Min	1167	1504.00	3.07	5388365.76	
<b>Specialized Medical Equipment and Supplies Total:</b>						9171538.18
Specialized Medical Equipment and Supplies	Cost of Equipment	8549	7.00	153.26	9171538.18	
<b>Personal Emergency Response Service (PERS) Total:</b>						3642715.80
Personal Emergency Response Service (PERS)	Monthly Monitoring	13227	9.00	30.60	3642715.80	

<b>Personal Assistance Services Total:</b>						185165852.90
Agency	15 Min	1384	5005.00	4.77	33041408.40	
Consumer	15 Min	7105	5110.00	4.19	152124444.50	
<b>Financial Management Services (FMS) Total:</b>						5435325.00
Financial Management Services (FMS)	Monthly	7105	10.00	76.50	5435325.00	
<b>Adult Daily Living Services Total:</b>						22030893.66
Adult Daily Living Full Day	Full Day	3375	101.00	63.38	21604657.50	
Adult Daily Living Half Day	Half Day	128	101.00	32.97	426236.16	
<b>Home Delivered Meals Total:</b>						10826988.80
Meal	Meal	7441	160.00	6.42	7643395.20	
Sandwich	Sandwich	6070	149.00	3.52	3183593.60	
<b>Home Support Total:</b>						10275980.94
Home Support	15 Min	4094	501.00	5.01	10275980.94	
<b>Transportation Total:</b>						4670925.00
Transportation	One Way Ride	4340	105.00	10.25	4670925.00	
<b>Personal Care Total:</b>						220410425.98
Personal Care	15 Min	20107	2075.00	5.24	218623411.00	
Personal Care Shift	Shift	103	534.00	32.49	1787014.98	
<b>TeleCare Total:</b>						1862925.12
Health Status Measuring and Monitoring Purchase	Per Purchase	224	31.00	167.28	1161592.32	
Health Status Measuring and Monitoring Per Diem	Daily	224	150.00	10.20	342720.00	
Activity and Sensor Monitoring Purchase	Purchase	224	2.00	204.00	91392.00	
Activity and Sensor Monitoring Monthly	Monthly	224	9.00	81.55	164404.80	
Medication Dispensing and Monitoring	Monthly	224	9.00	51.00	102816.00	
<b>Community Transition Services Total:</b>						2002402.65
Community Transition Services	One Time Purchase	771	1.00	2597.15	2002402.65	
<b>Environmental Modifications Total:</b>						3332249.40
Environmental Modifications	Per Purchase	1412	3.00	786.65	3332249.40	
<b>Counseling Total:</b>						1493375.40
Counseling	Visit	682	18.00	121.65	1493375.40	
<b>Home Health Care Total:</b>						5565011.98
Home Health Aide	Per Visit	164	193.00	41.54	1314824.08	
Nursing	Per Visit	1750	29.00	67.58	3429685.00	
Physical Therapy	Per Visti	363	20.00	79.74	578912.40	

Occupational Therapy	Per Visit	137	21.00	80.03	230246.31
Speech Therapy	Per Visit	11	13.00	79.33	11344.19
<b>GRAND TOTAL:</b>					496157106.89
Total Estimated Unduplicated Participants:					31350
Factor D (Divide total by number of participants):					15826.38
Average Length of Stay on the Waiver:					279

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Respite Total:</b>						5477259.94
Respite In Home	15 Min	423	833.00	5.30	1867502.70	
Respite In Home Shift	Shift	116	42.00	222.65	1084750.80	
Respite LTC Facility	Per Diem	634	22.00	181.03	2525006.44	
<b>Companion Services Total:</b>						6054280.75
Companion Services	15 Min	1225	1579.00	3.13	6054280.75	
<b>Specialized Medical Equipment and Supplies Total:</b>						9822526.56
Specialized Medical Equipment and Supplies	Cost of Equipment	8976	7.00	156.33	9822526.56	
<b>Personal Emergency Response Service (PERS) Total:</b>						3776285.16
Personal Emergency Response Service (PERS)	Monthly Monitoring	13444	9.00	31.21	3776285.16	
<b>Personal Assistance Services Total:</b>						192662249.60
Agency	15 Min	1453	5010.00	4.87	35451311.10	
Consumer	15 Min	7205	5110.00	4.27	157210938.50	
<b>Financial Management Services (FMS) Total:</b>						5622061.50
Financial Management Services (FMS)	Monthly	7205	10.00	78.03	5622061.50	
<b>Adult Daily Living Services Total:</b>						25678231.44
Adult Daily Living Full Day	Full Day	3543	110.00	64.65	25196044.50	
Adult Daily Living Half Day	Half Day	134	107.00	33.63	482186.94	
<b>Home Delivered Meals Total:</b>						11975323.32
Meal	Meal	7741	168.00	6.55	8518196.40	

Sandwich	Sandwich	6173	156.00	3.59	3457126.92	
<b>Home Support Total:</b>						11552422.28
Home Support	15 Min	4298	526.00	5.11	11552422.28	
<b>Transportation Total:</b>						5243284.20
Transportation	One Way Ride	4557	110.00	10.46	5243284.20	
<b>Personal Care Total:</b>						259614399.12
Personal Care	15 Min	21112	2285.00	5.34	257606512.80	
Personal Care Shift	Shift	108	561.00	33.14	2007886.32	
<b>TeleCare Total:</b>						2081279.85
Health Status Measuring and Monitoring Purchase	Per Purchase	235	33.00	170.63	1323235.65	
Health Status Measuring and Monitoring Per Diem	Daily	235	158.00	10.41	386523.30	
Activity and Sensor Monitoring Purchase	Purchase	235	2.00	208.08	97797.60	
Activity and Sensor Monitoring Monthly	Monthly	235	9.00	83.18	175925.70	
Medication Dispensing and Monitoring	Monthly	235	8.00	52.02	97797.60	
<b>Community Transition Services Total:</b>						2068939.29
Community Transition Services	One time Purchase	781	1.00	2649.09	2068939.29	
<b>Environmental Modifications Total:</b>						3568098.00
Environmental Modifications	Cost of Modification	1483	3.00	802.00	3568098.00	
<b>Counseling Total:</b>						1865666.88
Counseling	Visit	716	21.00	124.08	1865666.88	
<b>Home Health Care Total:</b>						6465938.31
Home Health Aide	Per Visit	172	205.00	42.37	1493966.20	
Nursing	Per Visit	1837	32.00	68.93	4051981.12	
Physical Therapy	Per Visti	381	21.00	81.33	650721.33	
Occupational Therapy	Per Visit	143	22.00	81.63	256807.98	
Speech Therapy	Per Visit	11	14.00	80.92	12461.68	
<b>GRAND TOTAL:</b>					553528246.20	
Total Estimated Unduplicated Participants:					34325	
Factor D (Divide total by number of participants):					16126.10	
Average Length of Stay on the Waiver:						279

## 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 (renewal only)**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Respite Total:</b>						<b>6009892.86</b>
Respite In Home	15 Min	444	874.00	5.41	2099382.96	
Respite In Home Shift	Shift	121	44.00	227.10	1209080.40	
Respite LTC Facility	Per Diem	665	22.00	184.65	2701429.50	
<b>Companion Services Total:</b>						<b>6797577.38</b>
Companion Services	15 Min	1286	1657.00	3.19	6797577.38	
<b>Specialized Medical Equipment and Supplies Total:</b>						<b>12022008.32</b>
Specialized Medical Equipment and Supplies	Cost of Equipment	9424	8.00	159.46	12022008.32	
<b>Personal Emergency Response Service (PERS) Total:</b>						<b>4493122.80</b>
Personal Emergency Response Service (PERS)	Monthly Monitoring	14116	10.00	31.83	4493122.80	
<b>Personal Assistance Services Total:</b>						<b>206588096.15</b>
Agency	15 Min	1525	5015.00	4.97	38009938.75	
Consumer	15 Min	7565	5111.00	4.36	168578157.40	
<b>Financial Management Services (FMS) Total:</b>						<b>6020983.50</b>
Financial Management Services (FMS)	Monthly	7565	10.00	79.59	6020983.50	
<b>Adult Daily Living Services Total:</b>						<b>28746956.00</b>
Adult Daily Living Full Day	Full Day	3720	115.00	65.94	28209132.00	
Adult Daily Living Half Day	Half Day	140	112.00	34.30	537824.00	
<b>Home Delivered Meals Total:</b>						<b>13202509.86</b>
Meal	Meal	7941	176.00	6.68	9336074.88	
Sandwich	Sandwich	6481	163.00	3.66	3866434.98	
<b>Home Support Total:</b>						<b>12929136.00</b>
Home Support	15 Min	4512	550.00	5.21	12929136.00	
<b>Transportation Total:</b>						<b>5921252.48</b>
Transportation	One Way Ride	4784	116.00	10.67	5921252.48	
<b>Personal Care Total:</b>						<b>292193986.60</b>
Personal Care	15 Min	22167	2400.00	5.45	289944360.00	
Personal Care Shift	Shift	113	589.00	33.80	2249626.60	
<b>TeleCare Total:</b>						<b>2403428.56</b>
Health Status Measuring and Monitoring Purchase	Per Purchase	247	35.00	174.04	1504575.80	
Health Status Measuring and Monitoring Per Diem	Daily				435031.22	

		247	166.00	10.61	
Activity and Sensor Monitoring Purchase	Purchase	247	3.00	212.24	157269.84
Activity and Sensor Monitoring Monthly	Monthly	247	9.00	84.84	188599.32
Medication Dispensing and Monitoring	Monthly	247	9.00	53.06	117952.38
<b>Community Transition Services Total:</b>					2129231.16
Community Transition Services	One time Purchase	788	1.00	2702.07	2129231.16
<b>Environmental Modifications Total:</b>					5094753.12
Environmental Modifications	Cost of Modification	1557	4.00	818.04	5094753.12
<b>Counseling Total:</b>					2091024.32
Counseling	Visit	751	22.00	126.56	2091024.32
<b>Home Health Care Total:</b>					7214724.70
Home Health Aide	Per Visit	180	215.00	43.22	1672614.00
Nursing	Per Visit	1887	34.00	70.31	4510948.98
Physical Therapy	Per Visti	400	22.00	82.96	730048.00
Occupational Therapy	Per Visit	150	23.00	83.26	287247.00
Speech Therapy	Per Visit	12	14.00	82.54	13866.72
<b>GRAND TOTAL:</b>					613858683.81
Total Estimated Unduplicated Participants:					37420
Factor D (Divide total by number of participants):					16404.56
Average Length of Stay on the Waiver:					279

## 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 (renewal only)

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Respite Total:</b>						6870977.04
Respite In Home	15 Min	466	905.00	5.52	2327949.60	
Respite In Home Shift	Shift	127	34.00	230.10	993571.80	
Respite LTC Facility	Per Diem	698	27.00	188.34	3549455.64	
<b>Companion Services Total:</b>						7081425.00
Companion Services	15 Min	1350	1614.00	3.25	7081425.00	

<b>Specialized Medical Equipment and Supplies Total:</b>						11220930.00
Specialized Medical Equipment and Supplies	Cost of Equipment	9895	7.00	162.00	11220930.00	
<b>Personal Emergency Response Service (PERS) Total:</b>						4713345.20
Personal Emergency Response Service (PERS)	Monthly Monitoring	14516	10.00	32.47	4713345.20	
<b>Personal Assistance Services Total:</b>						185704691.57
Agency	15 Min	1601	4011.00	5.07	32557567.77	
Consumer	15 Min	7843	4388.00	4.45	153147123.80	
<b>Financial Management Services (FMS) Total:</b>						5730252.66
Financial Management Services (FMS)	Monthly	7843	9.00	81.18	5730252.66	
<b>Adult Daily Living Services Total:</b>						29604383.43
Adult Daily Living Full Day	Full Day	3820	113.00	67.26	29033451.60	
Adult Daily Living Half Day	Half Day	147	111.00	34.99	570931.83	
<b>Home Delivered Meals Total:</b>						13012463.37
Meal	Meal	8138	166.00	6.81	9199683.48	
Sandwich	Sandwich	6681	153.00	3.73	3812779.89	
<b>Home Support Total:</b>						13859561.97
Home Support	15 Min	4737	551.00	5.31	13859561.97	
<b>Transportation Total:</b>						6230127.36
Transportation	One Way Ride	5023	114.00	10.88	6230127.36	
<b>Personal Care Total:</b>						318184384.00
Personal Care	15 Min	22567	2520.00	5.56	316190750.40	
Personal Care Shift	Shift	118	490.00	34.48	1993633.60	
<b>TeleCare Total:</b>						2271072.58
Health Status Measuring and Monitoring Purchase	Per Purchase	259	28.00	177.52	1287375.04	
Health Status Measuring and Monitoring Per Diem	Daily	259	174.00	10.82	487614.12	
Activity and Sensor Monitoring Purchase	Purchase	259	3.00	216.48	168204.96	
Activity and Sensor Monitoring Monthly	Monthly	259	9.00	86.54	201724.74	
Medication Dispensing and Monitoring	Monthly	259	9.00	54.12	126153.72	
<b>Community Transition Services Total:</b>						2242881.89
Community Transition Services	One Time Purchase	827	1.00	2712.07	2242881.89	
<b>Environmental Modifications Total:</b>						5366080.00
Environmental Modifications	Cost of Modification	1636	4.00	820.00	5366080.00	
<b>Counseling Total:</b>						1424120.88
Counseling	Visit	788	14.00	129.09	1424120.88	

<b>Home Health Care Total:</b>						<b>6792607.16</b>
Home Health Aide	Per Visit	189	224.00	43.50	<b>1841616.00</b>	
Nursing	Per Visit	1981	28.00	71.72	<b>3978164.96</b>	
Physical Therapy	Per Visti	420	21.00	84.62	<b>746348.40</b>	
Occupational Therapy	Per Visit	157	16.00	84.93	<b>213344.16</b>	
Speech Therapy	Per Visit	12	13.00	84.19	<b>13133.64</b>	
<b>GRAND TOTAL:</b>						<b>620309304.11</b>
Total Estimated Unduplicated Participants:						<b>37615</b>
Factor D (Divide total by number of participants):						<b>16491.01</b>
Average Length of Stay on the Waiver:						<b>279</b>