

Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	☒	Personal Assistance Services
Adult Day Health	☒	Adult Daily Living
Habilitation	☐	
Residential Habilitation	☒	
Day Habilitation	☒	Structured Day Habilitation Services
Prevocational Services	☒	Employment Skills Development
Supported Employment	☒	Job Coaching
Education	☐	
Respite	☒	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	
☐	Not applicable	
☒	As provided in 42 CFR §440.180(b)(9), the state requests the authority to provide the following additional services not specified in statute (<i>list each service by title</i>):	
a.	Assistive Technology	

b.	Behavior Therapy
c.	Benefits Counseling
d.	Career Assessment
e.	Cognitive Rehabilitation Therapy Services
f.	Community Integration
g.	Community Transition Services
h.	Home Adaptations
i.	Home Delivered Meals
j.	Job Finding
k.	Non-Medical Transportation
l.	Nutritional Consultation
m.	Participant-Directed Community Supports
n.	Participant-Directed Goods and Services
o.	Personal Emergency Response System (PERS)
p.	Pest Eradication
q.	TeleCare
r.	Vehicle Modifications
s.	Chore Services
☐	Not applicable
☒	The following extended state plan services are provided <i>(list each extended state plan service by service title)</i> :
a.	Counseling Services
b.	Home Health – Home Health Aide Services
c.	Home Health – Nursing Services
d.	Home Health – Occupational Therapy Services
e.	Home Health – Physical Therapy Services
f.	Home Health – Speech and Language Therapy Services
g.	Specialized Medical Equipment and Supplies
☐	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.

✓	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.	
○	Not applicable	
	Support	Included
	Information and Assistance in Support of Participant Direction	✓
	Financial Management Services	✓
Other Supports for Participant Direction (<i>list each support by service title</i>):		
a.		
b.		
c.		

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 <i>Do not complete item C-1-c.</i>
	☐ As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). <i>Complete item C-1-c.</i>
	☐ As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
	☒ As an administrative activity. <i>Complete item C-1-c.</i>
	☐ As a primary care case management system service under a concurrent managed care authority. <i>Complete item C-1-c.</i>
	☐ As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management). <i>Complete C-1-c.</i>

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

The CHC-MCO will provide service coordination as an administrative function. The Service Coordination function must be provided by an appropriately qualified Service Coordinator employed by or under contract with the CHC-MCO.

This service will be provided to meet the participant's needs as determined by an assessment performed in accordance with Department requirements, and as outlined in the participant's service plan.

Service Coordinators are responsible for assisting Participants in obtaining the services that they need. Service Coordinators lead the Person-Centered Service Planning process and oversee the implementation of Person-Centered Services Plans (PCSPs). CHC-MCOs must annually submit and obtain Department approval of their Service Coordination staffing, caseloads, the required frequency of in-person contact with Participants, and how Service Coordinators share and receive real-time information about Participants and Participant encounters.

Service Coordination includes activities to identify, coordinate and assist participants to gain access to needed Covered Services and non-Covered Services such as medical, social, housing, educational and other services and supports. Service Coordination includes the primary functions of providing information to Participants and facilitating access, locating, coordinating and monitoring needed services and supports for waiver Participants. Service Coordinators are responsible to: inform Participants about available LTSS, required needs assessments, the Participant-centered service planning process, service alternatives, service delivery options (opportunities for Participant-direction), roles, rights, risks and responsibilities, inform Participants on fair hearing rights and assist with fair hearing requests when needed and upon request, and ensuring the health, welfare and safety of the Participant on an on-going basis.

Service Coordinators must: collect information to inform the development of the PCSP, including, at a minimum, the Participant's preferences, strengths and goals; conduct the comprehensive needs assessment, at least annually or more frequently as needed in accordance with Department requirements; assist the Participant and his/her person-centered service planning team to identify and choose willing and qualified providers; coordinate efforts and prompt the Participant to complete activities necessary to maintain waiver eligibility; explore coverage of services to address Participant identified needs through other sources, including services provided under the State Plan, Medicare and/or private insurance or other community resources; and actively coordinate with other individuals and/or entities essential in the physical and/or behavioral care delivery for the Participant, including other care coordinators, to ensure seamless coordination between physical, behavioral and support services.

In the performance of the coordinating function, the Service Coordinator will:

- Coordinate efforts in accordance with Department requirements and prompt the participant to participate in the completion of a needs assessment as required by the State to identify appropriate levels of need and to serve as the foundation for the development of and updates to the service plan.
- Use a person-centered planning approach and a team process to develop the participant's service plan to meet the participant's needs in the least restrictive manner possible. At a minimum, the approach shall:
 - Include people chosen by the participant for service plan meetings, review assessments, including discussion of needs, to gain understanding of the participant's preferences, suggestions for services and other activities key to ensure a participant-centered service plan.
 - Provide necessary information and support to ensure that the participant directs the process to the maximum extent possible and is enabled to make informed choices and decisions.
 - Be timely and occur at times and locations of convenience to the participant.
 - Reflect cultural considerations of the participant.
 - Include strategies for solving conflict or disagreement within the process.
 - Offer choices to the participant regarding the services and supports they receive and the providers who may render them.
 - Inform participants of the method to request updates to the service plan.
 - Ensure and document the participant's participation in the development of the service plan.

- Develop and update the service plan in accordance with Appendix D, based upon the standardized needs assessment and participant-centered planning process annually, or more frequently as needed.
- Coordinate with the participant's family, friends and other community members to cultivate the participant's natural support network, to the extent that the participant (adult) has provided permission for such coordination.

In the performance of the monitoring function, the Service Coordinator will:

- Ensure that services are furnished in accordance with the service plan.
- Ensure that services meet participant needs.
- Monitor the health, welfare and safety of the participant and service plan implementation through regular contacts (monitoring visits with the participant, paid and unpaid caregivers and others) at a minimum frequency as required by the Department.
- Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health, welfare and safety of the participant in accordance with Appendix G.
- Monitor the effectiveness of back-up plans.
- Review provider documentation of service provision and monitor participant progress on outcomes and initiate service plan team discussions or meetings when services are not achieving desired outcomes.
- Through the service plan monitoring process, solicit input from participant and/or family, as appropriate, related to satisfaction with services.
- Arrange for modifications in services and service delivery, as necessary, to address the needs of the participant, consistent with an assessment of need and Department requirements, and modify the service plan accordingly.
- Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility and participant rights.
- Participate in any Department identified activities related to quality oversight.

Services must be delivered in a manner that supports the participant's communication needs, including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.

Service Coordination includes functions necessary to facilitate community transition for participants who received Medicaid-funded institutional services (i.e. Nursing Facilities) and who lived in an institution for at least 90 consecutive days prior to their transition to the waiver. Service Coordination activities for participants leaving institutions must be coordinated with, and must not duplicate, institutional discharge planning. This service may be provided up to 180 days in advance of anticipated movement to the community. Essential functions necessary for completion of a successful transition include at a minimum:

- Acting as a liaison between the facility where the participant will be transitioning from and the Independent Enrollment Entity for waiver services
- Performing a comprehensive assessment of the services needed to transition from an institution to the community, while assuring the participant's health and welfare. The comprehensive assessment gathers information about the need for health services, social supports, housing, transportation, financial resources and other needs.
- Providing information to the individual about community resources and assisting the individual, family, Nursing Facility staff and others to ensure timely and coordinated access to Medicaid services, behavioral health services, financial counseling and other services to meet needs.

- Providing housing pre-tenancy and transition services that prepare and support the participant's move to supportive housing in a community integrated setting. Functions include but are not limited to:
 - Conducting a housing assessment, including a comprehensive budget plan, to determine the participant's housing needs and preferences as well as identifying potential barriers to transition.
 - Developing an assessment-based housing support plan that identifies the housing services and supports required and will provide the participant with the opportunity to have an informed choice of living options.
 - Developing a crisis plan that identifies emergent situations that could jeopardize housing and the appropriate interventions.
 - Assisting with finding and securing housing, completing housing applications, and working with private landlords, housing authorities, Regional Housing Coordinators or other housing entities.
 - Assessing home adaptation needs. Acting as a liaison between contractors and physical or occupational therapists.
 - Assisting, or acting on the behalf of, the participant to obtain needed documentation (e.g., social security card, birth certificate, prior rental history), or resources with Social Security, social services, or community agencies.
 - Conducting or facilitating a housing inspection to ensure unit readiness for occupancy.
 - Coordinating the participant's move to the community and educating the individual on how to retain housing.
- Providing tenancy sustaining services to assist the participant to retain housing and integrate into the community, foster independence and assist in developing community resources to support successful tenancy and maintain residency in the community. Functions include but are not limited to:
 - Assisting or coordinating training to develop or restore skills on being a good tenant and/or neighbor and accessing community resources.
 - Assisting or coordinating training with necessary life skills such as budgeting and routine home maintenance.
 - Assisting the participant to manage and reduce behaviors that may jeopardize housing.
 - Assisting the participant to manage their household and understand the terms of a lease or mortgage agreement.
 - Monitoring and updating the participant's housing support plan as requisite housing skills change.

The following activities are excluded from Service Coordination:

- Outreach or eligibility activities (other than transition services) before participant enrollment in the waiver.
- Travel time incurred by the Service Coordinator may not be billed as a discrete unit of service.
- Services that constitute the administration of another program such as protective services, parole and probation functions, legal services, and public guardianship.
- Representative payee functions.
- Other activities identified by the Department.

Service Coordination must be conflict free and may only be provided by agencies and individuals employed by agencies who are not:

- Related by blood or marriage to the participant or to any paid service provider of the participant.
- Financially or legally responsible for the participant.
- Empowered to make financial or health-related decisions on behalf of the participant.
- Sharing any financial or controlling interest in any entity that is paid to provide care for or conduct other activities on behalf of the participant.
- Individuals employed by agencies paid to render direct or indirect services (as defined by the Department) to the participant, or an employee of an agency that is paid to render direct or indirect services to the participant.

CHC-MCOs must develop, submit for DHS approval, and implement a plan to monitor the performance of Service Coordinators.

Every Participant who has a PCSP developed must have a Service Coordinator assigned to implement and coordinate the services called for in the PCSP.

Service Coordinators and Service Coordinator supervisors must meet the following qualifications:

Service Coordinators must:

- Be a registered nurse (RN) or have a Bachelor's degree in social work, psychology or other related fields, or in lieu of a Bachelor's degree, have at least three (3) or more years of experience in a social service or health care related setting. Service Coordinators hired prior to the CHC zone Implementation Date must have the qualifications and standards proposed by the CHC-MCOs and approved by the department.
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52 except those excluded in the CHC Agreement;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
- Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Service Coordinator Supervisors must:

- Be an RN or have a Master's degree in social work or in a human services or healthcare field and three (3) years of relevant experience with a commitment to obtain either a Pennsylvania social work or mental health professional license within one year of hire. Service Coordinator Supervisors hired prior to the CHC zone Implementation Date (who do not have a license) must either 1) obtain a license within their first year under the new CHC contract in their zone or 2) have the qualifications and standards proposed by the CHC-MCOs and approved by the department.
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52 except those excluded in the CHC Agreement;
- Have criminal clearances as per 35 P.S. §10225.101 et seq. and 6 PA Code Chapter 15;
- Have a child abuse clearance (as per 23 PA C.S. Chapter 63); and
- Have a valid driver's license from Pennsylvania or a contiguous state if the operation of a vehicle is necessary to provide the service.

Service Coordination Entities under contract with the CHC MCO must:

- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52 except those excluded in the CHC Agreement;

- Meet the conflict free requirements pursuant to 55 PA Code, Chapter 52, §52.28;
- Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service;
- Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies;
- Have Commercial General Liability insurance; and
- Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the participant, for example, communication, mobility and behavioral needs.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

1. Will any in-person visits be required?

☐ Yes

☒ No

2. By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.

☒ The remote service will be delivered in a way that respects the privacy of the individual, especially in instances of toileting, dressing, etc. Explain:

- Teleservices must be provided by means that allow for live two-way communication with the participant, no recording of the interaction shall be captured. Live video or audio transmission is only allowable to persons designated by the participant and designated staff employed by the provider responsible for direct service delivery. Providers can call participants over the phone as an incidental component of teleservices to check-in with participants as allowed in the service definition or in emergency circumstances when all other criteria are met. Monitoring of devices is not allowable under teleservices.
- The provider must explain to the participant and everyone else residing in the home the impact that teleservices will have on their privacy. The Service Coordinator must discuss privacy concerns with the participant and confirm the provider has educated the participant on their privacy policy. This must be documented in the PCSP.
 - o The use of live video communication devices in bathrooms is strictly prohibited as part of teleservices.
 - o It is allowable for staff to provide live audio prompts needed by the participant in bathrooms and bedrooms as part of teleservices. The participant must be alerted prior to the activation of any audio communication device unless the participant turns on the audio communication device themselves.

o Live real time video communication between the participant and a staff person as part of teleservices may only occur in a participant's bedroom when all of the following are met and documented:

- The participant has chosen to receive teleservices in their bedroom due to a medical condition which makes it difficult or impossible for them to leave their bedroom to receive services in another room in the house or the participant would like privacy from others in the home (family, housemates, etc.) during the receipt of services;
- The participant turns the video communication device on and off themselves or requests assistance in turning the video communication device on and off;
- The participant does not share a bedroom with others; and
- Service delivery via video communication will not be performed as part of any activity during which privacy would generally be expected (while a participant is in a state of undress, during sexual activities, etc.).

o All live real time audio and video communication devices used to render teleservices in any part of the home or community must include indicators that let the participant know that the equipment is on and operating in audio or video mode.

☒ How the telehealth service delivery will facilitate community integration. Explain:

Telehealth Service delivery reduces barriers by improving access to care for participants who have been assessed that using remote technology is the most appropriate service delivery method to meet the participant's needs (including health and safety needs) and goals. Telehealth Services may be provided in the home and/or in the community.

Improved access to care includes:

- Connecting participants in rural or underserved areas to providers
- Reducing transportation barriers
- Providing on-going monitoring
- Providing self-management tools to increase independence
- Access to diverse providers
- Follow-up support to assist participants integrate into or back into the community safely

☒ How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. Explain:

The following direct services may be rendered via teleservices:

- Cognitive Rehabilitation Therapy Services
- Counseling Services
- Nutritional Consultation
- Behavior Therapy Services
- Benefits Counseling

These services do not require hands on assistance/physical assistance.

☒ How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. Explain:

Providers will work with the ISP planning team to determine the appropriate technology that will work best for the participant.

The provider is responsible for ensuring that any technology used to render teleservices are HIPAA compliant and that the delivery of teleservices has been reviewed and accepted by the HIPAA compliance officer.

Providers are responsible for providing initial and ongoing training and support to the participant, and anyone designated by the participant, regarding the operation of the technology used during teleservices, including turning it on and off at-will.

The provider, in conjunction with the Person-Centered Planning team, must develop a back-up plan that will be implemented should there be a problem with the technology.

☒ How the telehealth will ensure the health and safety of an individual. Explain:

Participants must have an informed choice to receive direct services in-person or via teleservices. Teleservices may only occur when the participant and the Person-Centered Planning team determines that using remote technology is the most appropriate service delivery method to meet the participant's needs (including health and safety needs) and goals. This determination will include consideration of how teleservices will promote improved health and welfare.

Appendix C-2: General Service Specifications

- 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*):

●	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): Criminal history checks are required for all direct care workers and must be conducted in accordance with 55 PA Code, Sections 52.19 and 52.20. Direct care workers who are employed by waiver participants must have criminal history clearances completed prior to hire, facilitated through the FEA as described below, so that participants can make an informed decision on whether to employ a worker who has a criminal record. All applicants are required to obtain a report of criminal history from the Pennsylvania State Police (PSP) which access the Pennsylvania Crime Information Center (PCIC) and the National Crime Information Center (NCIC). The results are typically available within 1-2 business days. For applicants who have resided in Pennsylvania for less than two years, a fingerprint-based Federal Bureau of Investigation (FBI) federal criminal history record is also 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, as well as the results of the background check. Under participant-direction, the CHC-MCOs' Fiscal Employer/Agent (F/EA) vendor is responsible for securing criminal history background checks for prospective direct care workers prior to hiring workers. In addition, the F/EA must have a system in place to 1) document that the criminal history background check was conducted, and 2) notify individuals of the results of the background check, and 3) document the individual's decision to employ a direct care worker with a criminal record and their acceptance of responsibility for their decision. The CHC-MCOs, as part of their oversight of the F/EA contract, will ensure that criminal background checks will be completed timely. Staff will check to determine that criminal background checks are completed timely and that participants are notified of results. Corrective action will be implemented if it is found that the F/EA is not meeting established contract standards. The CHC-MCO will review provider personnel records as part of their regular monitoring to ensure that criminal history checks are conducted and documented as required. In addition to regularly scheduled monitoring, OLTL may review records as necessary during incident report investigations or other circumstances as warranted.
○	No. Criminal history and/or background investigations are not required.

- 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*):

- **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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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):

Clearances are required for all direct care workers and service providers, including Service Coordinators and contractors, providing services in homes where children reside. A child is defined as an individual under 18 years of age.

The following three certifications must be obtained prior to providing services in homes where children reside:

- Report of criminal history from the Pennsylvania State Police (PSP);
- Fingerprint-based federal criminal history submitted through the Pennsylvania State Police or its authorized agent (FBI); and
- Child Abuse History Certification from the Department of Human Services (Child Abuse).

The option to provisionally hire a person for employment described in 55 Pa. Code Ch. 52.20 does not apply to the clearances required prior to providing services in homes where children reside.

Requests for criminal history reports can be processed through the Pennsylvania State Police web-based computer application called “Pennsylvania Access To Criminal History” (PATCH), at <https://epatch.state.pa.us>, or by submitting the “Request For Criminal Record Check” form SP4-164 (updated 12/2017) to the following address: Pennsylvania State Police, Central Repository – 164, 1800 Elmerton Avenue, Harrisburg, PA 17110-9758, (888) 783-7972.

The Department of Human Services utilizes IDEMIA, also referred to as IdentoGo and MorphoTrust, to process fingerprint-based FBI record checks. The fingerprint-based background check is a multiple step process. The IDEMIA website: <https://www.identogo.com/> allows individuals to apply online, as well as provide detailed information regarding the application process.

Child Abuse History Certifications are obtained online at <http://www.compass.state.pa.us/CWIS>, or through the DHS ChildLine and Abuse Registry, P.O. Box 8170, Harrisburg, Pennsylvania 17105-8170, (717) 783-6211 or toll free at (877) 371-5422.

For those workers required to have clearances (see above), written results are required prior to the employee/provider initiating services in the participant’s home. Direct care workers who are employed by waiver participants who have children residing in their homes must have child abuse clearances completed prior to hire so that participants can make an informed decision on whether to employ a worker who has been named as a perpetrator of founded or indicated child abuse.

	Certifications must be obtained every 60 months regardless of service model. Any employee with current certification must renew their certifications within 60 months from the date of their oldest certification or if their current certification is older than 60 months. If an employee is arrested for or convicted of an offense that would constitute grounds for denying employment or participation in a program, activity or service, or is named as a perpetrator in a founded or indicated report, the employee must provide the administrator or their designee with written notice not later than 72 hours after the arrest, conviction or notification that the person has been listed as a perpetrator in the statewide database. An employee who willfully fails to disclose information as required above commits a misdemeanor of the third degree and shall be subject to discipline up to and including termination or denial of employment. The employer, administrator, supervisor or other person responsible for employment decisions or acceptance of the individual to serve in any capacity requiring certifications, must have a system in place to document that the clearances were conducted and shall maintain copies of the required information. The CHC-MCOs' F/EA vendor is responsible for securing clearances for prospective direct care workers. In addition, the F/EA must have a system in place to document that the clearances were conducted. The CHC-MCOs, as part of their oversight of the F/EA contract, will ensure that child abuse clearances will be completed timely. Staff will check to determine that child abuse clearances are completed timely. Corrective action will be implemented if it is found that the F/EA is not meeting established contract standards. The CHC-MCO will review provider personnel records as part of their regular monitoring to ensure that child abuse clearances are conducted and documented as required. In addition to regularly scheduled monitoring, OLTL may review records as necessary during incident report investigations or other circumstances as warranted.
☐	No. The state does not conduct abuse registry screening.

c. **Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.**

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 *or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child).* At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. 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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar

	services provided by a legally responsible individual is “extraordinary care”, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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 <i>specific circumstances</i> and only when the relative/guardian is qualified to furnish services. Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state’s process for ensuring that the relative/legal guardian uses substituted judgment on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.</i> Family members can provide Respite, Personal Assistance Services and Participant-Directed Community Supports; however, the following exclusions apply: • The CHC Waiver will not pay for services furnished by the participant’s spouse. • The CHC Waiver will not pay for services furnished by a legal guardian. • The CHC Waiver will not pay for services furnished by a Representative Payee. • The CHC Waiver will not pay for services furnished by a Power of Attorney (POA).

	Aside from the exceptions noted above, there are no restrictions on the types of family members who may provide Respite, Personal Assistance Services and Participant-Directed Community Supports. Family members who provide Respite, Personal Assistance Services and Participant-Directed Community Supports must meet the same provider qualification standards as direct care workers who provide Respite, Personal Assistance Services and Participant-Directed Community Supports to non-relatives. Individual service plans for individuals who receive more than 40 hours per week of Respite, Personal Assistance Services and Participant-Directed Community Supports services from one individual (family member or non-family member) will be reviewed and approved by the CHC-MCO. The CHC-MCOs will monitor the provision of services in accordance with OLTL established protocols. Like all providers, family members who provide Respite, Personal Assistance Services and Participant-Directed Community Supports must submit signed time sheets of service delivery hours to the F/EA. The F/EA will review authorized billable units through the CHC-MCO's billing system. Reimbursement for services will be made through the CHC-MCOs. The F/EA shall receive and maintain electronic authorization data from the MCO for each self-directed service appearing on the service plan and authorized by the MCO. When a common-law employer (CLE) submits a timesheet for their employee, the F/EA will ensure that units are available based on the available authorization(s) and that the DCW is paid at the rate established by their CLE.
☐	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. <i>Specify:</i>

- 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:

As a condition of participation in the CHC waiver, potential providers must meet the requirements set forth in 55 PA Code, Chapter 52, as well as other applicable regulatory provisions. OLTL maintains responsibility for ensuring providers meet the approved provider qualifications, including certification and licensure, as referenced in the Quality Improvement section below. In addition, OLTL is responsible for enrolling qualified providers as a Medicaid waiver provider. All willing and qualified providers have the opportunity to enroll as waiver providers with OLTL at any time; OLTL has continuous open enrollment of providers and does not limit the application for provider enrollment to a specific time frame. Copies of the forms for provider enrollment are available upon request from the OLTL and are also available to potential providers online through the DHS website: https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx
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OLTL will forward a list of all enrolled providers to the CHC-MCOs on a monthly basis. The CHC-MCO will choose the providers they will contract with as part of their provider network from this list of providers. CHC-MCOs are required to contract with a sufficient number of providers to demonstrate network adequacy.

- g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act.** Specify whether the state chooses the option to provide the waiver HCBS in acute care hospitals. Select one:

- ☒ No, the state does not choose the option to provide HCBS in acute care hospitals.
- ☐ Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. ***By checking the boxes below, the state assures:***
- ☐ The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;
 - ☐ The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;
 - ☐ The HCBS must be identified in the individual's person-centered service plan, and
 - ☐ The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

And specify:

- a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;
- b) How the 1915(c) HCBS will assist the individual in returning to the community; and
- c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*check each that applies*).

☐	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; and, (f) how participants are notified of the amount of the limit.

☐	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. <i>Furnish the information specified above.</i>
☐	Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i>
☐	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. <i>Furnish the information specified above.</i>
☐	Other Type of Limit. The state employs another type of limit. <i>Describe the limit and furnish the information specified above.</i>

Appendix C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are received. *(Specify and describe the types of settings in which waiver services are received)*

OLTL services are provided in the private homes of individuals and integrated community settings. HCBS services in the CHC Waiver can be provided in the following settings:

Private residences

Provider Owned and Controlled Settings that integrated into the community.

- Residential Habilitation- Licensed Residential Habilitation Provider: Personal Care Home per 55 PA Code 2600 or Assisted Living Residences per 55 PA Code 2800 and CARF Community Housing Accreditation or CARF Brain Injury Residential Rehabilitation Program (Adult) accreditation.
- Other Provider Owned & Controlled Site- Settings where two or more unrelated participants live and receive HCBS, and the setting is owned and/or operated by an entity that also has a financial interest in an HCBS provider agency and/or settings that are providing services to these individuals.

Day Settings that are integrated into the community.

- Structured Day Habilitation- CARF Community Integration accreditation, or CARF Brain Injury Home and Community Services (Adult) accreditation or be licensed under 55 PA Code Chapter 2380 as an Adult Training Facility
- Adult Day Center-Licensed under Title 6 PA Code, Chapter 11, Subchapter A and/or Title 55 PA Code, Chapter 2380, Subchapter A

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings in which HCBS are received meet federal HCB settings requirements, at the time of this submission and in the future as part of the ongoing monitoring.

(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which HCBS are received. All OLTL HCSB settings must comply with the HCBS Rule (42 CFR § 441.301(c)(4)), and the following characteristics must be present in each setting where HCBS are provided for the setting to be considered home and community-based. All settings must meet the criteria outlined in federal requirements.

- It is integrated in and supports full access to the greater community.
- It is selected by the individual from among a variety of setting options.
- It optimizes autonomy and independence in making life choices.
- It facilitates individual choice in selecting both services and service providers.

- It ensures individuals rights of privacy, dignity, respect, and freedom from coercion and restraint.

OLTL utilizes the following approaches to assess compliance with the HCBS Rule statewide:

- Self-assessments (through provider self-survey)
- Onsite Assessment Process and Heightened Scrutiny Onsite Reviews
- OLTL Policies and HCBS Final Rule Processes
- Quality Assurance & Improvement (QA & I) for all Settings.

Prior to any new provider enrollment, OLTL's Bureau of Fee-For-Service Programs, Division of Provider Operations accepts applications from providers electing to enroll to render HCBS that includes questions and information related to the HCBS Rule. The types of questions a provider must respond to are specific to the service location where HCBS is rendered, pose qualities to isolate participants from the greater community, third-party relationships, and the financial interest of owners of residential settings. Applicants that are identified as not in compliance with the final rule will be required to complete the provider self-survey and may be subject to an onsite visit by OLTL as well as submission to CMS for heightened scrutiny prior to enrollment or may have to take additional steps to become compliant with the rule before their enrollment is considered complete.

For enrolled HCBS waiver providers, OLTL utilizes the Quality Management Efficiency Team (QMET), who are OLTL's regional provider monitoring agents, to assess and monitor compliance with the HCBS Rule (42 CFR § 441.530). Each regional QMET is comprised of a program specialist (regional team lead), social workers, and fiscal representatives. Four teams are located throughout the state of Pennsylvania. Utilizing a standardized monitoring process, including the HCBS Onsite Assessment Tool, QMET completed on site assessment of provider sites that included a visual inspection of the site where HCBS occur, as well as participant file reviews, interviews of available staff/recipients, and a review of the site's policies and procedures.

The QMET are responsible for continued monitoring of provider sites for compliance after the final compliance deadline to ensure that sites continue to meet the requirements of the rule. OLTL waiver providers are monitored for compliance with OLTL waiver and program requirements biennially by the regional QMET through the use of the HCBS Onsite Assessment Tool which captures all required criteria.

The HCBS Onsite Assessment tool used by the QMET assists with determining the level of compliance at each service location. Areas of noncompliance with the HCBS Settings requirements identified from the HCBS Onsite Assessment Tool are communicated to the provider through a State of Findings (SoF). Providers are required to formally respond to the SoF by submitting a Corrective Action Plan (CAP) to OLTL. The CAP must provide detail about the steps to be taken to remediate any compliance issues, including action steps to address specific findings, explanation on how the steps will

remediate the identified compliance issue, the date when a finding will be remediated, and the agency responsible person for correcting the item.

OLTL has developed a final rule panel comprised of representatives from each of the CHC-MCOs, licensing entities, and OLTL staff to review the findings of the QMET assessment to ensure ongoing compliance with the HCBS Rule. The panel is also responsible for validating a site's claim that they do not have qualities of an institutional setting or isolating conditions. Additionally, the panel will review all complaints received regarding potential noncompliant sites. In addition, the final rule panel reviews and votes on final approval of all CAPs that were submitted by providers.

Once a CAP is approved, the QMET determines the CAP follow-up reassessment schedule as outlined in the State's approved Statewide Transition Plan (STP). Once all the action items are verified as complete, the QMET recommends the closure of the CAP by the Final Rule Panel. Upon the Panel's approval the CAP is closed. OLTL also provides guidance and technical assistance to providers to assist them with ongoing compliance. Providers that do not remain compliant with the HCBS final rule may be subject to sanctions including but not limited to termination from participation with the OLTL waivers and programs.

There is also a role for the CHC-MCOs and Service Coordinators. OLTL requires the CHC-MCOs to identify any concerns related the HCBS Final Rule as Service Coordinators work with participants during the PCSP process. For all participants who receive HCBS through OLTL, Service Coordinators are required at least yearly through the annual re-determination process to review all available service delivery options and document the participant's choice. Service Coordinators are responsible for ensuring participants are fully informed of all services available in the waiver, their right to choose from and among all willing and qualified providers that are part of the CHC-MCOs provider network, and document evidence of participant choice. Service Coordinators are also responsible for providing participants with information and training on their rights and the HCBS Rule during the PCSP development process. This includes confirming that the setting where the participant resides is chosen by the individual and is integrated and supports full access to the community in accordance with the participant's goals. Participant choices made are reflected in the PCSP. At every assessment and re-assessment participants are given the choice to receive HCBS services in a setting of their choice including non-disability specific settings. Any identified concerns related to compliance with the HCBS settings requirements must be brought to OLTL's attention.

HCBS services may not be provided in settings that are presumed to have institutional qualities and do not meet the rule's requirements for home and community-based settings.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☒ The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

☒ The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (*see Appendix D-1-d-ii*)

☒ Ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.

☒ Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

☒ Facilitates individual choice regarding services and supports, and who provides them.

☒ Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

☐ No, the waiver does not include provider-owned or controlled settings.

☒ Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☒ The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form

of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

☒ Each individual has privacy in their sleeping or living unit:

☒ Units have entrance doors lockable by the individual:

☒ Only appropriate staff have keys to unit entrance doors.

☒ Individuals sharing units have a choice of roommates in that setting.

☒ Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement

☒ Individuals have the freedom and support to control their own schedules and activities.

☒ Individuals have access to food at any time.

☒ Individuals are able to have visitors of their choosing at any time.

☒ The setting is physically accessible to the individual.

☒ Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan (*See Appendix D-1-d-ii of this waiver application*).