Changes to the OBRA Waiver Effective 7/1/2026 (Renewal)

KEY – **Bold** = Recommended additions
Strikethrough = Recommended removal

Waiver Section	Current Approved Language	Recommended Revised Language	Reason for the Change
Entire Waiver Application	CMS issued revisions to the 1915(c) HCBS Waiver Application and Technical Guide. The new application is known as Version 3.7.	Changes were made to the 1915(c) Waiver application template in the following Appendices: *Appendices B, C, D, E, I, Main Module, and Quality Improvement Sections of all Appendices.	Improve understanding of applicable federal policies and their implications for the design and operation of an HCBS waiver and provide the review criteria that CMS uses to determine whether a waiver meets applicable statutory, regulatory, and other requirements.
Appendix A-1(3)	Specifically, the Independent Enrollment Entity (IEE) is responsible for the following activities: • Complete the initial in-home visit and needs assessment; • Educate individuals on their rights and responsibilities in the waiver program, opportunities for self-direction, appeal rights, the Services and Supports Directory, and the right to choose from any qualified provider; • Provide applicants with choice of receiving ICF-ORC institutional services, waiver services, or no services and documenting the applicant's choice on the OLTL Freedom of Choice Form; • Provide applicants with a list of qualified Service Coordination agencies and document the individual's choice of Service Coordinator on the OLTL Service Provider Choice Form; • Assist the applicant to obtain a completed physician certification form from the individual's physician;	Specifically, the Independent Enrollment ~~Entity~~ **Broker** (IE~~E~~**B**) is responsible for the following activities: • Complete the initial in-home visit and needs assessment; • Educate individuals on their rights and responsibilities in the waiver program, opportunities for self-direction, appeal rights, the Services and Supports Directory, and the right to choose from any qualified provider; • Provide applicants with choice of receiving ICF-ORC institutional services, waiver services, or no services and documenting the applicant's choice on the OLTL Freedom of Choice Form; • Provide applicants with a list of qualified Service Coordination agencies and document the individual's choice of Service Coordinator on the OLTL Service Provider Choice Form; • Assist the applicant to obtain a completed physician certification form from the individual's physician; • Refer the applicant to the independent Assessment Entity for the functional eligibility determination;	Update language to current terminology of Independent Enrollment Broker (IEB). Added beneficiary support services (BSS) to the responsibilities of the IEB.

	• Refer the applicant to the independent Assessment Entity for the functional eligibility determination; • Assist the participant to complete the financial eligibility determination paperwork; • Facilitate the transfer of the new enrollee to their selected Service Coordination Entity, including sending copies of all completed assessments and forms; and • Maintain a waiting list for services as necessary.	• Assist the participant to complete the financial eligibility determination paperwork; • Facilitate the transfer of the new enrollee to their selected Service Coordination Entity, including sending copies of all completed assessments and forms; ~~and~~ • Maintain a waiting list for services as necessary; **and** • **Conduct beneficiary support services (BSS).**	
Appendix A-1(6)	OLTL has undertaken a number of efforts to strengthen the methods for overseeing entities performing administrative elements on behalf of the SMA. Through redrafting of contracts for entities performing administrative functions on behalf of the Commonwealth with specific reporting criteria to establishing programmatic and fiscal regulations, OLTL has established firmer footing upon which to base a strong assessment method and frequency for monitoring. OLTL is contracting with an independent Assessment Entity to conduct the initial Functional Eligibility Determinations of participants. A contract manager, who will be an employee of OLTL, will be assigned to this contract and will require quarterly reports on timeliness of the determinations and the agency's adherence to the contract requirements. OLTL will aggregate information on findings from the Assessment Entity to ascertain trends in non-compliance areas. Data will be presented at the Quality Management Meeting (QM2) to discuss the areas of non-compliance and develop statewide strategies to reverse negative trends. Strategies include issuing or re-issuing instructions to the Assessment Entity regarding performance obligations, implementing or revising training on the Assessment Entity's responsibilities, or recommending contract revisions. A yearly report on all program requirements will also be required and reviewed for compliance.	~~OLTL has undertaken a number of efforts to strengthen the methods for overseeing entities performing administrative elements on behalf of the SMA. Through redrafting of contracts for entities performing administrative functions on behalf of the Commonwealth with specific reporting criteria to establishing programmatic and fiscal regulations, OLTL has established firmer footing upon which to base a strong assessment method and frequency for monitoring.~~ **OLTL holds contracts with selected entities to perform certain administrative elements on behalf of the SMA. OLTL has established standardized processes for oversight and monitoring of contracted entities.** **Independent Assessment Entity:** OLTL **contracts** ~~is contracting~~ with an independent Assessment Entity to conduct the initial Functional Eligibility Determinations of participants. A contract manager, ~~who will be an employee of OLTL,~~ **located in the Bureau of Coordinated and Integrated services, is** ~~will be~~ assigned to this contract and ~~will~~ require**s** quarterly reports on timeliness of the determinations and the agency's adherence to the contract requirements. **Monthly and yearly reports on all program requirements will also be required and reviewed for compliance.** **The IAE is required to request and complete all assessments electronically through the OLTL assessment system. As assessment results are submitted, the assessment system captures all**	Revised language regarding the methods OLTL uses to assess the performance of contracted entities to ensure they perform their designated activities as required. The previous language was outdated.

	OLTL oversees the contractual obligations of the Fiscal/Employer Agent (F/EA). OLTL staff conduct an onsite annual operational review of the contracted F/EA to ensure that all required functions are performed in accordance with all OLTL requirements including the Waiver assurances and the F/EA contract. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other vendors. In addition to the annual onsite operational review, there is significant oversight conducted on a monthly basis. The contract requires the F/EA to provide OLTL with monthly utilization reports, quarterly and annual status reports, as well as problem identification reports; these reports cover activities performed and issues encountered during the reporting period. OLTL will utilize these reports to monitor performance to ensure services are being delivered according to the contract. If the F/EA exhibits noncompliance in any area of the waiver or contract, it will receive a Statement of Findings. The F/EA is required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of noncompliance. The CAP is due to OLTL within 15 days of issuance of findings to the F/EA. OLTL reviews and approves or disapproves the CAP within 15 days of receipt. The F/EA is expected to implement the approved CAP. If the F/EA does not develop a satisfactory CAP, OLTL will draft a CAP and require the F/EA to implement the OLTL drafted CAP. A satisfactory CAP requires the provider to resolve the finding in a reasonable amount of time given the resources available. OLTL reviews the CAP to ensure the provider's plan to resolve the finding is both timely and complete. Through a follow-up onsite review, OLTL validates	**corresponding information and populates various reports that the OLTL can review and monitor during regular intervals (daily, weekly, monthly, quarterly, annually). Reports include information on contract requirements and waiver assurances.** ~~OLTL will aggregate information on findings from the Assessment Entity to ascertain trends in non-compliance areas. Data will be presented at the Quality Management Meeting (QM2) to discuss the areas of non-compliance and develop statewide strategies to reverse negative trends. Strategies include issuing or re-issuing instructions to the Assessment Entity regarding performance obligations, implementing or revising training on the Assessment Entity's responsibilities, or recommending contract revisions. A yearly report on all program requirements will also be required and reviewed for compliance.~~ **Fiscal/Employer Agent:** OLTL**'s Bureau of Fee For Service Programs** oversees the contractual obligations of the Fiscal/Employer Agent (F/EA) **using operations reports that are submitted to the Bureau monthly.** OLTL staff conduct an onsite annual operational review of the contracted F/EA to ensure that all required functions are performed in accordance with all OLTL requirements including the Waiver assurances and the F/EA contract. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other vendors. In addition to the annual onsite operational review, there is significant oversight conducted on a monthly basis. The contract requires the F/EA to provide OLTL with monthly utilization reports, quarterly and annual status reports, as well as problem identification reports; these	

	that corrective actions are taken to remediate each instance of noncompliance within a prescribed timeframe and that other necessary actions are taken to avoid a recurrence. F/EA findings are also presented at the Quality Management Meeting (QM2) to discuss the areas of non-compliance and develop statewide strategies to improve F/EA performance. Strategies include issuing or re-issuing instructions to the F/EA regarding performance obligations, implementing or revising training for the F/EA, participants or participant's workers on their responsibilities, or recommending contract revisions. The Office of Long Term Living also oversees the performance of the enrollment function which has been delegated to the Independent Enrollment Entity. The Independent Enrollment Entity (IEE) is monitored annually on contracted performance measures. In addition to the annual contract monitoring, OLTL oversees ongoing operation through IEE performance on contracted performance measures that are collected monthly from the IEE and provided to the contract administrator and the Metrics and Analytics Division within the office of the Chief of Staff. Performance measures include sufficient staff to ensure calls are answered by a live person, at least 95% of the time, and the average phone wait time is less than 60 seconds for 100% of the calls. Other measures ensure timeliness of specific tasks such as conducting initial visits within seven days and forwarding information to the chosen Service Coordination Entity within two days. Systems information is contained in the contractor's Datamart database and it is loaded to OLTL to validate reports. If the Independent Enrollment Entity fails to meet established performance measure standards it must respond to the findings and remediate areas of non-compliance. If the Independent Enrollment Entity fails to	reports cover activities performed and issues encountered during the reporting period. OLTL will utilize these reports to monitor performance to ensure services are being delivered according to the contract. ~~If the F/EA exhibits noncompliance in any area of the waiver or contract, it will receive a Statement of Findings. The F/EA is required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of noncompliance. The CAP is due to OLTL within 15 days of issuance of findings to the F/EA. OLTL reviews and approves or disapproves the CAP within 15 days of receipt. The F/EA is expected to implement the approved CAP. If the F/EA does not develop a satisfactory CAP, OLTL will draft a CAP and require the F/EA to implement the OLTL drafted CAP. A satisfactory CAP requires the provider to resolve the finding in a reasonable amount of time given the resources available. OLTL reviews the CAP to ensure the provider's plan to resolve the finding is both timely and complete. Through a follow-up onsite review, OLTL validates that corrective actions are taken to remediate each instance of noncompliance within a prescribed timeframe and that other necessary actions are taken to avoid a recurrence.~~ ~~F/EA findings are also presented at the Quality Management Meeting (QM2) to discuss the areas of non-compliance and develop statewide strategies to improve F/EA performance. Strategies include issuing or re-issuing instructions to the F/EA regarding performance obligations, implementing or revising training for the F/EA, participants or participant's workers on their responsibilities, or recommending contract revisions.~~ **Independent Enrollment Broker:** **OLTL contracts with a statewide Independent Enrollment Broker (IEB) to facilitate the waiver enrollment process. The IEB is managed in the OLTL Bureau of Coordinated and Integrated**	

	remediate non-compliance it can result in adverse action against the contracted entity, including contract termination.	**Services and assessed with bi-weekly face-to-face or conference call meetings. Performance management as part of the contract includes the following performance measures and data collection:** **• Data for all open applications, detailed weekly** **• Open applications by time period, weekly summary** **• Number of applications at each status in the eligibility process, weekly summary** **• All Unduplicated Applications in process during identified time period, detailed monthly** **• Timeliness for detailed activities between major milestones, detailed monthly** **• Reasons for delayed in-home visit, monthly summary** **• Application timeliness, detailed monthly and quarterly** **• Problem identification report, as required** **• Performance measurement reports measuring timeliness and target criteria the contractor must meet or exceed, monthly.** **In addition, OLTL has included specific Service Level Agreements (SLAs) in the IEB contract which OLTL uses to hold the vendor accountable to identified levels of performance.** ~~The Office of Long Term Living also oversees the performance of the enrollment function which has been delegated to the Independent Enrollment Entity. The Independent Enrollment Entity (IEE) is monitored annually on contracted performance measures. In addition to the annual contract monitoring, OLTL oversees ongoing operation through IEE performance on contracted performance measures that are collected monthly from the IEE and provided to the contract administrator and the Metrics and Analytics Division within the office of the Chief of Staff. Performance measures include sufficient staff to ensure calls are answered by a live person, at least 95% of the time, and the average phone wait time is less than 60 seconds for 100% of the calls. Other measures ensure timeliness of specific tasks such as conducting initial visits within seven days and~~	

		~~forwarding information to the chosen Service Coordination Entity within two days. Systems information is contained in the contractor's Datamart database and it is loaded to OLTL to validate reports. If the Independent Enrollment Entity fails to meet established performance measure standards it must respond to the findings and remediate areas of non-compliance. If the Independent Enrollment Entity fails to remediate non-compliance it can result in adverse action against the contracted entity, including contract termination.~~ **Areas of noncompliance are shared and reviewed internally with OLTL Bureau Directors, Division Directors and/or their designees, SMEs and other OLTL staff pertinent to discuss any necessary follow-up actions. When the deficiency is significant or ongoing, the supporting vendor or direct service provider may be required to develop a CAP. The plan must include methods for remedying the areas of deficiency, including timeframes to complete the actions. CAPs must be submitted to OLTL for approval within 15 working days of the request. OLTL reviews and approves the CAP within 30 working days of submission. OLTL monitors plan implementation to determine if the area of deficiency has been corrected within the established timeframes. If the deficiency has not been corrected, the supporting vendor or direct service provider will receive additional technical assistance and, in some cases, a new CAP will be requested, or financial sanctions will be imposed.**	
Appendix B-6(c)	One year experience in the AAA system may be substituted for one year assessment experience. The equivalency statement under "Minimum Requirements" means that related advanced education may be substituted for a segment of the experience requirement and related experience may be substituted for required education except for the required 12 semester hours in the above majors.	One year experience in the **Area Agency on Aging** 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.	Spelled out Area Agency on Aging and removed the outdated reference to the qualifications for AAA Case Managers. Corrected level of care from Nursing Facility for ICF/ORC.

	The complete qualifications of the AAA Case Managers are located at the Department of Aging website at http://www.aging.state.pa.us; click on Aging Program Directives link then Home and Community Based Services Procedural Manual. Physicians Physicians are licensed through the Pennsylvania Department of State under the following regulations: • Chapter 17 State Board of Medicine – Medical Doctors • Chapter 25 State Board of Osteopathic Medicine The applicant's physician is responsible for completing the physician's certification form (MA-51). OLTL does not contract directly with physicians to perform participant evaluations. When a participant presents to the independent enrollment broker (IEB), the IEB sends a request to the applicant's primary care physician to fill out and return a physician's script indicating that the waiver applicant requires the level of care provided in a Nursing Facility.	~~The complete qualifications of the AAA Case Managers are located at the Department of Aging website at http://www.aging.state.pa.us; click on Aging Program Directives link then Home and Community Based Services Procedural Manual.~~ Physicians Physicians are licensed through the Pennsylvania Department of State under the following regulations: • Chapter 17 State Board of Medicine – Medical Doctors • Chapter 25 State Board of Osteopathic Medicine The applicant's physician is responsible for completing the physician's certification form. OLTL does not contract directly with physicians to perform participant evaluations. When a participant presents to the independent enrollment broker (IEB), the IEB sends a request to the applicant's primary care physician to fill out and return a physician's script indicating that the waiver applicant requires the level of care provided in a**n** ~~Nursing Facility~~ **ICF/ORC**.	
Appendix B-6(d)	Currently, the local Area Agency on Aging (AAA) uses the Level of Care Determination (LCD) to determine the individual's disability, age of on-set and functional limitations.	Currently, the local Area Agency on Aging (AAA) uses the ~~Level of Care Determination (LCD)~~ **Functional Eligibility Determination (FED)** to determine the individual's disability, age of on-set and functional limitations.	Corrected terminology from Level of Care Determination (LCD) to Functional Eligibility Determination (FED)
Appendix B-6(f)	OLTL maintains Administrative Authority over the evaluation and reevaluation processes by monitoring the timeliness and appropriateness of LOC evaluations and reevaluations	OLTL maintains Administrative Authority over the evaluation and reevaluation processes by monitoring the timeliness and appropriateness of ~~LOC~~ **FED** evaluations and reevaluations	Corrected terminology from Level of Care Determination (LCD) to Functional Eligibility Determination (FED)
Appendix B-6(i)	The Service Coordinators are required to collect the information necessary for redeterminations every 365 days or more frequently, if needed, when there are changes in a participant's functioning and/or needs.	The Service Coordinators are required to collect the information necessary for redeterminations every 365 days or more frequently, if needed, when there are changes in a participant's functioning and/or needs. **If a trigger event occurs, the Service Coordinator (SC) must complete a Reassessment as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, but in no case more than**	Added language regarding need for the SC to reassess a participant if a trigger event were to occur or if the participant were to be without services to assist with activities of daily living, as indicated on the service plan, for five

		fourteen (14) days after the occurrence of the following trigger events: • **A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings, or a hospital discharge.** • **A change in functional status.** • **A change in caregiver or informal support status if the change impacts one or more areas of health or functional status.** • **A change in the home setting or environment if the change impacts one or more areas of health or functional status.** • **A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning.** • **As requested by the Participant or designee, caregiver, Provider, or the Individual Service Planning Team (ISPT) or ISPT Participant, or the Department.** **In addition to the trigger events listed above, if the SC identifies that a Participant has not been receiving services to assist with activities of daily living, as indicated on the service plan, for five (5) consecutive scheduled days of service or more, and the suspension of services was not pre-planned, the SC must communicate with the Participant to determine the reason for the service suspension within 24 hours of identifying the issue. If a Participant receives an alternative HCBS in this five (5) day span during which activities of daily living are addressed, outreach by the SC is not required.** **If, after communicating, the SC determined that the Participant's health status or needs have changed, then the SC must conduct a Reassessment within fourteen (14) days of identifying the issue. Unless one of the trigger events listed in this section occur, the Reassessment cannot be conducted more than sixty (60) days prior to the one-year mark of the last Assessment date.**	consecutive scheduled days. This aligns with CHC.

Appendix B-7(a)	All individuals who are determined to be eligible to receive community services in the waiver will be informed in writing, initially by the IEE and ongoing by their Service Coordinator, of their right to choose between receiving community services in the waiver, institutional (ICF/ORC) services, remain in their present program, or choose not to receive services. All eligible participants will execute his/her choice by completing the OLTL Freedom of Choice Form during the initial enrollment process and on-going as part of the person-centered planning process. Documentation is made in the participant's file that the form was completed; completed forms are maintained in the participant's file. Participant Freedom of Choice of Providers The independent enrollment entity is responsible for ensuring that all individuals who are determined eligible for waiver services are given a list of all enrolled Service Coordination Entities, and documenting the participant's choice of service coordinator on the OLTL Service Provider Choice Form.	All individuals who are determined to be eligible to receive community services in the waiver will be informed in writing, initially by the ~~IEE~~ **IEB** and ongoing by their Service Coordinator, of their right to choose between receiving community services in the waiver, institutional (ICF/ORC) services, remain in their present program, or choose not to receive services. All eligible participants will execute his/her choice by completing the OLTL Freedom of Choice Form during the initial enrollment process and on-going as part of the person-centered planning process. Documentation is made in the participant's file that the form was completed; completed forms are maintained in the participant's file. Participant Freedom of Choice of Providers The ~~independent enrollment entity~~ **IEB** is responsible for ensuring that all individuals who are determined eligible for waiver services are given a list of all enrolled Service Coordination Entities, and documenting the participant's choice of service coordinator on the OLTL Service Provider Choice Form.	Update language to current terminology of Independent Enrollment Broker (IEB).
Appendix B-8	In addition, OLTL's contract with the Independent Enrollment Entity (IEE) requires the IEE to provide enrollment documents as well as language assistance available upon request, at no charge.	In addition, OLTL's contract with the ~~Independent Enrollment Entity (IEE)~~ **IEB** requires the ~~IEE~~ **IEB** to provide enrollment documents as well as language assistance available upon request, at no charge.	Update language to current terminology of Independent Enrollment Broker (IEB).
Appendix C-1(d) Main Module	All teleservice language removed from the Main Module and added to this section in Appendix C.	**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**	CMS revisions to the waiver application (Version 3.7) include adding a section specifically regarding Teleservices. All information regarding Teleservices was removed from the Main Module section of the waiver and added to the new section in Appendix C-1(d).

		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 has explained to the participant and everyone else residing in the home the impact that teleservices will have on their privacy. The Service Coordinator has discussed privacy concerns with the participant and confirmed the provider has educated the participant on their privacy policy. This must be documented in the ISP.** **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.)** **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.** **☒ 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 is 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(b)	Beginning July 1, 2015, certifications must be obtained every 60 months regardless of service model. Any employee with current certification issued prior to July 1, 2015 must renew their certifications within 60 months from the date of their oldest certification or if their current certification is older than 60 months.	~~Beginning July 1, 2015, c~~ **Certifications** must be obtained every 60 months regardless of service model. Any employee with current certification ~~issued prior to July 1, 2015,~~ must renew their certifications within 60 months from the date of their oldest certification or if their current certification is older than 60 months.	Removed outdated language
Appendix C-2(f)	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: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/index.htm	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: ~~http://www.dhs.pa.gov/provider/promise/enrollmentinformation/in~~	Corrected web address.

		~~dex.htm~~ **https://www.pa.gov/agencies/dhs/resources/for-providers/promise**	
Appendix C-5(2)	N/A	***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 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**	With the new 1915(c) version 3.7 application, CMS added check boxes for the state to assure that settings meets the HCBS Setting Rule requirements.

		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).***	
Appendix D-1(b)	OLTL monitors receipt of the forms as part of its biennial provider reviews by OLTL as listed in the Quality Improvement section in Appendix H.	OLTL monitors receipt of the forms as part of its biennial provider reviews by OLTL**'s Quality Management Efficiency Teams** ~~as listed in the Quality Improvement section in Appendix H~~. … **The state has established the following safeguards to mitigate the potential for conflict of interest in the service plan development. *By checking each box, the state attests to having a process in place to ensure:*** **☒ Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services,**	Clarify QMET's monitoring responsibility. With the new 1915(c) version 3.7 application, CMS added check boxes for the state to attest that a process is in place to ensure conflict free service planning.

		not just the services furnished by the entity that is responsible for the person-centered service plan development; **☒ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;** **☒ Direct oversight of the process or periodic evaluation by a state agency;** **☒ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and** **☒ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**	
Appendix D-1(d)	The Service Coordinator schedules the service planning meetings at times and places that are convenient to the participant.	The Service Coordinator schedules the service planning meetings at times and places that are convenient to the participant. **ISPs must be developed and implemented no later than 15 business days from the date the comprehensive needs assessment or reassessment is completed.**	Aligning service plan development timelines to CHC.
Appendix D-1(d)(ii)	N/A	**HCBS Settings Requirements for the Service Plan. By checking these boxes, the state assures that the following will be included in the service plan:** **☒ 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.** **☒ For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person- centered service plan and the following will be documented in the person-centered service plan:** **☒ A specific and individualized assessed need for the modification.**	With the new 1915(c) version 3.7 application, CMS added this section for the state to assure that the HCBS Settings Rule is incorporated in service planning.

		Positive interventions and supports used prior to any modifications to the person-centered service plan. Less intrusive methods of meeting the need that have been tried but did not work. **☒ A clear description of the condition that is directly proportionate to the specific assessed need. Regular collection and review of data to measure the ongoing effectiveness of the modification.** **☒ Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.** **☒ Informed consent of the individual.** **☒ An assurance that interventions and supports will cause no harm to the individual.**	
Appendix D-1(f)	At time of enrollment, the independent enrolling agency educates participants that they have the right to choose the providers of the services they will receive, including Service Coordination providers, and their right to choose a different provider for different services.	At time of enrollment, the ~~independent enrolling agency~~ **Independent Enrollment Broker** educates participants that they have the right to choose the providers of the services they will receive, including Service Coordination providers, and their right to choose a different provider for different services.	Update language to current terminology of Independent Enrollment Broker (IEB).
Appendix D-2(a)	The Service Coordinator plays a key role in ensuring the implementation and monitoring of the ISP as follows: • Monitors the health and safety of the participant and the quality of services provided to the participant through personal visits at a minimum of twice per year and telephone calls at least quarterly. Personal visits and telephone contacts may be done more frequently as agreed upon by the participant and team to assure provision of services and health and welfare of the participant or in accordance with OLTL requirements. The Service Coordinator is responsible for completing the Department approved Participant Monitoring Tool during at least one of the face-to-face visits during the year. During monitoring contacts, the SC is responsible for discussing the following information with the participant and documenting the information in HCSIS service notes for review by OLTL: o The participant is receiving the amount, frequency, and duration of services that are in the approved ISP.	The Service Coordinator plays a key role in ensuring the implementation and monitoring of the ISP **and adherence to the HCBS settings requirements** as follows: • Monitors the health and safety of the participant and the quality of services provided to the participant through personal visits at a minimum of twice per year and telephone calls at least quarterly. Personal visits and telephone contacts may be done more frequently as agreed upon by the participant and team to assure provision of services and health and welfare of the participant or in accordance with OLTL requirements. The Service Coordinator is responsible for completing the Department approved Participant Monitoring Tool during at least one of the face-to-face visits during the year. During monitoring contacts, the SC is responsible for discussing the following information with the participant and documenting the information in HCSIS service notes for review by OLTL: o The participant is receiving the amount, frequency, and duration of services that are in the approved ISP.	Added language requires the Service Coordinator to include the HCBS Settings requirements in service planning.

	o The participant is receiving the authorized services that are in the ISP. o The participant is receiving the amount of support necessary to ensure health and safety. o If the participant has reported any health status or other events (such as a hospitalization, scheduled surgery, etc.) or changes o There is no duplication of services including waiver and non-waiver services. o Contacts with individuals, families and providers. o Ensures that each participant has a comprehensive ISP that meets the identified needs of the participant and is implemented as indicated on the ISP. o That the recommended and chosen services are being implemented. o That the back-up plan is effective and how often it has been used.	o The participant is receiving the authorized services that are in the ISP. o The participant is receiving the amount of support necessary to ensure health and safety. o If the participant has reported any health status or other events (such as a hospitalization, scheduled surgery, etc.) or changes o There is no duplication of services including waiver and non-waiver services. o Contacts with individuals, families and providers. o Ensures that each participant has a comprehensive ISP that meets the identified needs of the participant and is implemented as indicated on the ISP. o That the recommended and chosen services are being implemented. o That the back-up plan is effective and how often it has been used. **o The setting is integrated in and supports full access for the participant to the greater community.** **o The participant selects the setting from setting options including non-disability specific settings and an option for a private unit in a residential setting. This must be documented in the ISP.** **o Ensures participant's rights of privacy, dignity and respect, and freedom from coercion or restraint.** **o Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environments, and social interactions.** **o Facilitates individual choice regarding services and supports and who provides them.** **o In a provider-owned or controlled residential setting, the following conditions must be met:** • **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. The individual has, at a minimum, the same responsibilities and**	

		protections from eviction that tenants have under the local landlord/tenant law. • **Each individual has privacy in their sleeping or living unit:** - **Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.** - **Individuals sharing units have a choice of roommates.** - **Individuals may furnish and decorate their sleeping or living units within the lease or other agreement.**	
Appendix D-2(b)	N/A	**The state has established the following safeguards to mitigate the potential conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*** **☒ Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;** **☒ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;** **☒ Direct oversight of the process or periodic evaluation by a state agency;** **☒ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and** **☒ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**	With the new 1915(c) version 3.7 application, CMS added check boxes for the state to attest that there are safeguards in place to ensure conflict free service plan monitoring, health and welfare and adherence to the HCBS Settings Rule.

<table>
<tr>
<td>Appendix E-1(i)(i)</td>
<td>Financial Management Services are provided to participants across the Commonwealth by one qualified Fiscal Employer Agent, which was selected through a competitive procurement process (RFA).
In early 2012, the Department of Human Services issued a Request for Application (RFA) to secure up to three entities that will provide Vendor F/EA Financial Management Services throughout the Commonwealth or on a regional basis for participants who receive participant-directed services in the OBRA waiver. One statewide vendor F/EA was selected as a result of the RFA.</td>
<td>Financial Management Services are provided to participants across the Commonwealth by one qualified Fiscal Employer Agent, which was selected through a competitive procurement process (RFA).
~~In early 2012, the Department of Human Services issued a Request for Application (RFA) to secure up to three entities that will provide Vendor F/EA Financial Management Services throughout the Commonwealth or on a regional basis for participants who receive participant-directed services in the OBRA waiver. One statewide vendor F/EA was selected as a result of the RFA.~~</td>
<td>Removed outdated language.</td>
</tr>
<tr>
<td>Appendix E-1(n)
Table E-1-n</td>
<td>
<table>
<tr><td></td><td>Employer Authority Only</td><td>Budget Authority Only or Budget Authority in Combination with Employer Authority</td></tr>
<tr><td>Waiver Year</td><td>Number of Participants</td><td>Number of Participants</td></tr>
<tr><td>Year 1</td><td>279</td><td></td></tr>
<tr><td>Year 2</td><td>287</td><td></td></tr>
<tr><td>Year 3</td><td>295</td><td></td></tr>
<tr><td>Year 4</td><td>303</td><td></td></tr>
<tr><td>Year 5</td><td>311</td><td></td></tr>
</table>
</td>
<td>
<table>
<tr><td></td><td>Employer Authority Only</td><td>Budget Authority Only or Budget Authority in Combination with Employer Authority</td></tr>
<tr><td>Waiver Year</td><td>Number of Participants</td><td>Number of Participants</td></tr>
<tr><td>Year 1</td><td>~~279~~ 180</td><td></td></tr>
<tr><td>Year 2</td><td>~~287~~ 182</td><td></td></tr>
<tr><td>Year 3</td><td>~~295~~ 185</td><td></td></tr>
<tr><td>Year 4</td><td>~~303~~ 189</td><td></td></tr>
<tr><td>Year 5</td><td>~~311~~ 195</td><td></td></tr>
</table>
</td>
<td>Updated OLTL’s goals for unduplicated number of waiver participants who are expected to elect participant direction. The numbers were revised downward to reflect fewer overall participants in the OBRA waiver after the implementation of CHC.</td>
</tr>
<tr>
<td>Appendix E-1(i)(iv)</td>
<td>OLTL will monitor the selected vendor to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. The statewide vendor will be monitored by QMET annually. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the</td>
<td>OLTL ~~will~~ monitors the selected vendor through an operations report to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. ~~The statewide vendor will be monitored by QMET annually.~~ OLTL ~~will~~ monitors the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax ~~fillings~~ filings on behalf of the participant, and executed agreements between the</td>
<td>Revised language regarding the methods OLTL uses to assess the performance of the F/EA to ensure they perform their designated activities as required. The previous language was outdated.</td>
</tr>
</table>

	participant, and executed agreements between the F/EA and the workers or other vendors. If the F/EA is not in compliance with contractual or waiver provisions, OLTL will issue a Statement of Findings. The F/EA will be required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of non-compliance. The CAP is due to OLTL within 15 days of issuance of findings to the F/EA. OLTL reviews and approves or disapproves the CAP within 15 days of receipt. OLTL will conduct follow-up monitoring activities to ensure the CAP is instituted and identified issues are remediated. In addition to the process described above, OLTL will monitor performance through the use of monthly utilization reports, quarterly and annual status reports, as well as problem identification reports. These reports cover activities performed and issues encountered during the reporting period. OLTL will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary. Service Coordinators will also be required to report any issues with the statewide FMS organization's performance to OLTL. Lastly, the F/EA will conduct a Common Law Employer Satisfaction Survey using the survey tool provided by the Department. The survey must be conducted 60 days after enrolling a new common law employer and annually. Survey data must be collected and analyzed by the F/EA, and a report must be prepared and submitted to OLTL based upon specifications determined by the Department. Through the established claims oversight process, OLTL will monitors claim submitted by the F/EA to ensure the payments to the vendor for both administrative fees and services are in accordance with all applicable regulations and requirements.	F/EA and the workers or other vendors~~. If the F/EA is not in compliance with contractual or waiver provisions, OLTL will issue a Statement of Findings. The F/EA will be required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of non-compliance. The CAP is due to OLTL within 15 days of issuance of findings to the F/EA. OLTL reviews and approves or disapproves the CAP within 15 days of receipt. OLTL will conduct follow-up monitoring activities to ensure the CAP is instituted and identified issues are remediated. In addition to the process described above, OLTL will monitor performance through the use of monthly utilization reports, quarterly and annual status reports, as well as problem identification reports. These reports cover activities performed and issues encountered during the reporting period. OLTL will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary. Service Coordinators will also be required to report any issues with the statewide FMS organization's performance to OLTL.~~ **Areas of noncompliance are shared and reviewed internally with OLTL Bureau Directors, Division Directors and/or their designees, SMEs and other OLTL staff pertinent to discuss any necessary follow-up actions. When the deficiency is significant or ongoing, F/EA may be required to develop a Corrective Action Plan (CAP). The CAP must include methods for remedying the areas of deficiency including timeframes to complete the actions. CAPs must be submitted to OLTL for approval within 15 working days of the request. OLTL reviews and approves the CAP within 30 working days of submission. OLTL monitors plan implementation to determine if the area of deficiency has been corrected within the established timeframes. If the deficiency has not been corrected, the supporting vendor or direct service provider will receive additional technical assistance and, in some cases, a new CAP will be requested, or financial sanctions will be imposed.**	

		Lastly, the F/EA will conduct a Common Law Employer Satisfaction Survey using the survey tool ~~provided~~ **approved** by the Department. The survey must be conducted 60 days after enrolling a new common law employer and annually. Survey data must be collected and analyzed by the F/EA, and a report must be prepared and submitted to OLTL based upon specifications determined by the Department. Through the established claims oversight process, OLTL will monitors claim submitted by the F/EA to ensure the payments to the vendor for both administrative fees and services are in accordance with all applicable regulations and requirements.	
Appendix E-1(j)	In early 2012, the Department of Human Services issued a Request for Application (RFA) to secure up to three entities to provide Financial Management Services throughout the Commonwealth or on a regional basis for participants who receive participant-directed services in the OBRA waiver. One statewide vendor F/EA was selected as a result of the RFA. The selected F/EA organization receives a monthly per participant administrative fee for the FMS administrative service provided by the F/EA. *** OLTL will monitor the selected F/EA to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. The statewide F/EA will be monitored by QMET annually. OLTL will monitor the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other vendors. If the FMS organization is not in Application for 1915(c)	~~In early 2012, the Department of Human Services issued a Request for Application (RFA) to secure up to three entities to provide Financial Management Services throughout the Commonwealth or on a regional basis for participants who receive participant-directed services in the OBRA waiver. One statewide vendor F/EA was selected as a result of the RFA.~~ The ~~selected~~ F/EA organization receives a monthly per participant administrative fee for the FMS administrative service provided by the F/EA. *** OLTL ~~will~~ monitor**s** the ~~selected~~ F/EA **through an operations report** to ensure that the contract deliverables are met and participants are in receipt of Financial Management Services in accordance with their ISP. ~~The statewide F/EA will be monitored by QMET annually.~~ OLTL ~~will~~ monitor**s** the FMS organization's performance of administrative activities, as well as adherence to contract conditions and waiver requirements. These requirements include, but are not limited to, participant satisfaction, timeliness and accuracy of payments to workers, accuracy of information provided to participants and workers by the F/EA, timeliness and accuracy of tax fillings on behalf of the participant, and executed agreements between the F/EA and the workers or other vendors. Areas of noncompliance are shared and reviewed internally with OLTL Bureau Directors, Division	Revised language regarding the methods OLTL uses to assess the performance of the F/EA to ensure they perform their designated activities as required. The previous language was outdated.

	HCBS Waiver: PA.0235.R06.07 - Jan 01, 2025 (as of Jan 01, 2025) Page 258 of 353 12/16/2024 compliance with a contractual or waiver provisions, OLTL will issue a Statement of Findings. The F/EA will be required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of noncompliance. OLTL will conduct follow-up monitoring activities to ensure the CAP is instituted and identified issues are remediated. In addition to the process described above, OLTL will monitor performance through the use of quarterly and annual status reports as well as problem identification reports. These reports cover activities performed and issues encountered during the reporting period. OLTL will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary.	Directors and/or their designees, SMEs and other OLTL staff pertinent to discuss any necessary follow-up actions. When the deficiency is significant or ongoing, the supporting vendor or direct service provider may be required to develop a Corrective Action Plan (CAP). The CAP must include methods for remedying the areas of deficiency including timeframes to complete the actions. CAPs must be submitted to OLTL for approval within 15 working days of the request. OLTL reviews and approves the CAP within 30 working days of submission. OLTL monitors plan implementation to determine if the area of deficiency has been corrected within the established timeframes. If the deficiency has not been corrected, the supporting vendor or direct service provider will receive additional technical assistance and, in some cases, a new CAP will be requested, or financial sanctions will be imposed. ~~If the FMS organization is not in Application for 1915(c) HCBS Waiver: PA.0235.R06.07 - Jan 01, 2025 (as of Jan 01, 2025) Page 258 of 353 12/16/2024 compliance with a contractual or waiver provisions, OLTL will issue a Statement of Findings. The F/EA will be required to develop a Corrective Action Plan (CAP) in response to each finding and remediate areas of noncompliance. OLTL will conduct follow-up monitoring activities to ensure the CAP is instituted and identified issues are remediated. In addition to the process described above, OLTL will monitor performance through the use of quarterly and annual status reports as well as problem identification reports. These reports cover activities performed and issues encountered during the reporting period. OLTL will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary.~~	
Appendix F-1	The IEE is required to provide information on due process and appeal rights to the applicant utilizing OLTL issued standard forms when the following circumstances occur: *** The IEE/Service Coordinator are required to make all such notices in writing utilizing OLTL issued documents.	The ~~IEE~~ **IEB** is required to provide information on due process and appeal rights to the applicant utilizing OLTL issued standard forms when the following circumstances occur: *** The ~~IEE~~ **IEB**/Service Coordinator are required to make all such notices in writing utilizing OLTL issued documents.	Update language to current terminology of Independent Enrollment Broker (IEB).

	*** It is the responsibility of the Service Coordinator/IEE to provide any assistance the participant/applicant needs to request a hearing.	*** It is the responsibility of the Service Coordinator/**IEB** ~~IEE~~ to provide any assistance the participant/applicant needs to request a hearing.	
Appendix F-3(c)	Participants, family members and other interested parties use the HelpLine to report complaints/grievances regarding the provision/timeliness of services, provider performance and reports of alleged abuse, neglect or exploitation. When an individual calls the OLTL HelpLine with a complaint/grievance, the calls are logged by OLTL and the information is then referred to the appropriate Bureau for resolution. Complaints are classified as Urgent if immediate action is required to assist in safeguarding the participant's health and welfare or Non-Urgent if the participant is not at risk of immediate health and jeopardy and immediate action is not required. Any complaints determined to be an incident as described in Appendix G are entered into EIM as an incident and are treated as such for purposes of investigation and follow-through. *** Documentation of any actions and the resolution is entered into the database by OLTL staff and the complaint is submitted through EIM for supervisory review. The reviewing supervisor can accept the resolution allowing for closure of the complaint or send it back to staff for further action. The timeframe for additional follow-up and resolution is 45 days, but additional time can be requested through EIM in accordance with OLTL requirements. OLTL is able to generate reports from EIM about the types of participant complaints received, timeliness of resolution and examines general patterns and trends for system improvement. In addition, EIM is designed to collect complaints received from any source, such as direct phone calls, emails, and letters or	Participants, family members and other interested parties use the HelpLine to report complaints/grievances **(hereinafter complaints) regarding** the provision/timeliness of services, provider performance**, person-centered planning requirements, the HCBS Settings Rule,** and reports of alleged abuse, neglect or exploitation. **Complaints can also be submitted in writing.** When an individual **or the individual's representative** calls the OLTL HelpLine with a complaint~~/grievance~~ **or submits one in writing**, the ~~calls~~ **complaints** are logged by OLTL and the information is then referred to the appropriate Bureau for resolution. Complaints are classified as Urgent if immediate action is required to assist in safeguarding the participant's health and welfare or Non-Urgent if the participant is not at risk of immediate health and jeopardy and immediate action is not required. Any complaints determined to be an incident as described in Appendix G are entered into ~~EIM~~ **the complaint database** as an incident and are treated as such for purposes of investigation and follow-through. *** Documentation of any actions and the resolution is entered into the database by OLTL staff and the complaint is submitted through ~~EIM~~ **the complaint database** for supervisory review. The reviewing supervisor can accept the resolution allowing for closure of the complaint or send it back to staff for further action. The timeframe for additional follow-up and resolution is **60** ~~45~~ days, but additional time can be requested through ~~EIM~~ **the complaint database** in accordance with OLTL requirements. OLTL is able to generate reports from ~~EIM~~ **the complaint database** about the types of participant	Language added to comply with the CMS Ensuring Access to Medicaid Services Final Rule (Access Rule) which requires states to implement a grievance system for Fee for service waivers. In Pennsylvania grievances are called complaints. This renewal updates OLTL's existing complaint process to meet requirements of the Access Rule. The timeframe to resolve a complaint is extended from 45 days to 60 days due to additional steps in the complaint resolution process required by the Access Rule and 42 CFR 441.301(c)(7).

	faxes in order to standardize collection and processing of all complaints in one data collection system. Participants are informed verbally and in the OLTL Participant Information Packet about the OLTL Participant HelpLine at enrollment, during their annual reevaluation, and in the cover letter that accompanies the OLTL Participant Satisfaction Surveys. Participants are advised through OLTL's standard participant information materials that OLTL's grievance/complaint system is neither a pre-requisite, nor a substitute for a fair hearing.	complaints received, timeliness of resolution and examines general patterns and trends for system improvement. In addition, ~~EIM~~ **the complaint database** is designed to collect complaints received from any source, such as direct phone calls, emails, and letters or faxes in order to standardize collection and processing of all complaints in one data collection system. **The date the complaint is received, the date of each review, the date and manner of the resolution and the name of the participant are also recorded by OLTL in the Complaint Database.** Participants are informed verbally and in the OLTL Participant Information Packet about **the ability to file complaints and** the OLTL Participant HelpLine at enrollment, during their annual reevaluation, and in the cover letter that accompanies the OLTL Participant Satisfaction Surveys. Participants are advised through OLTL's standard participant information materials that OLTL's ~~grievance/~~complaint system is neither a pre-requisite, nor a substitute for a fair hearing. **OLTL maintains policies and procedures that explain the complaint process and that meet the conditions set forth in 42 CFR 441.301(c)(7).**	
Appendix H-1(a)(i)	The Division of Quality Assurance in BQAPA is responsible for collecting discovery and remediation information, analyzing that information, recommending system improvements and analyzing the effectiveness of the improvement initiatives. This Division is comprised of the Quality Review Team and the Clinical Review Team. The functions of the Division of Quality Assurance are: • Conduct quality monitoring of long-term living programs and services to ensure compliance with federal and state regulations and the 6 waiver assurances • Compile reports on data for the 6 waiver assurances to measure the effectives of program design and suggest	The Division of Quality Assurance **(DQA)** in BQAPA is responsible for collecting discovery and remediation information, analyzing that information, recommending system improvements and analyzing the effectiveness of the improvement initiatives. This Division is comprised of the Quality Review Team and the Clinical Review Team. The functions of the ~~Division of Quality Assurance~~ **DQA** are: • Conduct quality monitoring of long-term living programs and services to ensure compliance with federal and state regulations and the 6 waiver assurances • ~~Compile~~ **Review** reports on data for the 6 waiver assurances to measure the effectives of program design and suggest improvement initiatives	Revised language regarding the methods OLTL uses to assess the performance of contracted entities to ensure they perform their designated activities as required. The previous language was outdated.

	improvement initiatives • Use data to support the development and implementation of policies and protocols to ensure quality program outcomes • Collaborate with other bureaus in OLTL to develop and implement training and technical assistance for staff, providers and participants to ensure quality service delivery and consistent policy communication • Collaborate with other bureaus in the OLTL, external stakeholders, other state agencies to effectively implement the QIS • Recommend strategies for continuous quality improvement • Maximize the quality of life, functional independence, health and welfare and satisfaction of participants in OLTL waivers The following CMS Waiver Assurances are evaluated based on approved waiver performance measures. There are several reports performed by Subject Matter Experts (SMEs) in OLTL that provide the data for the waiver performance measures. The performance measures are analyzed by the Division of Quality Assurance to implement the QIS. Each performance measure report listed below was designed to collect the data needed to ensure compliance with the CMS Waiver Assurances. The Division of Quality Assurance works with various other bureaus and divisions in the OLTL to ensure the reports and data collected are valid and compiled correctly. The reports are monitored for irregular or unusual data and compliance issues. Administrative Authority Assurance: Six Performance Measures • Level of Care Determination Report - Annually • Independent Enrollment Broker Contractual Obligation Report - Quarterly • Initial and Annual Level of Care Report - Annually • Qualified Provider Report - Quarterly	• Use data to support the development and implementation of policies and protocols to ensure quality program outcomes • Collaborate with other bureaus in OLTL to develop and implement training and technical assistance for staff, providers and participants to ensure quality service delivery and consistent policy communication • Collaborate with other bureaus in the OLTL, external stakeholders, **and** other state agencies to effectively implement the QIS • Recommend strategies for continuous quality improvement • Maximize the quality of life, functional independence, health and welfare and satisfaction of participants in OLTL waivers The ~~following~~ CMS Waiver Assurances are evaluated based on approved waiver performance measures. There are several reports performed by Subject Matter Experts (SMEs) in OLTL that provide the data for the waiver performance measures. The performance measures are analyzed by the ~~Division of Quality Assurance~~ **DQA** to implement the QIS. ~~Each performance measure report listed below was designed to collect the data needed to ensure compliance with the CMS Waiver Assurances.~~ The ~~Division of Quality Assurance~~ **DQA** works with various other bureaus and divisions in the OLTL to ensure the reports and data collected are valid and compiled correctly. The reports are monitored for irregular or unusual data and compliance issues. **OLTL uses the following reports and tools to capture the data necessary to assess ongoing performance and compliance with the 1915(c) waiver performance measures.** **1. OPS-101, Independent Assessment Entity (IAE) Waiver Assurance Monitoring Report – a standard monthly report which outlines the two key requirements as defined in the IAE's contract. This report is used to determine the IAE's compliance with one of the Administrative Authority and Level of Care performance measures.**	

	Level of Care Assurance: Two Performance Measures • Annual Level of Care Report - Annually • Initial Level of Care Report - Annually Qualified Provider Assurance: Five Performance Measures • Qualified Provider Report - Quarterly • Initial Provider Enrollment Report - Quarterly Service Plan Assurance: Eight Performance Measures • Service Plan Assurance Data Report - Annually • Participant Satisfaction Survey Results - 3 times per year • QMET Report on Service Delivery - Quarterly • Enterprise Incident Management (EIM) Report on Complaints - Monthly/On Demand Health and Welfare Assurance: Fourteen Performance Measures • EIM Reports on Complaints and Incidents - Monthly/On Demand • Participant Satisfaction Survey Reports - 3 times per year • Service Plan Assurance Data Report - Annually Financial Accountability Assurance: Five Performance Measures • Onsite Paid Claims Report - Quarterly • PROMISe Paid Claims Report - Annually • PROMISe Claims/Rate Setting and Payment Report - Annually After completing their reports, OLTL SMEs provide the Division of Quality Assurance with the data for the performance measures. The performance measures obtained are reviewed by the Division of Quality Assurance. Data is analyzed and reviewed for each waiver assurance to ensure the reports and performance measures collected are valid. If non-compliance or low compliance is identified, the bureaus and divisions in OLTL	**2. OPS-102, Independent Enrollment Broker (IEB) Waiver Assurance Monitoring Report – a standard quarterly report which outlines the seven key requirements as defined in the IEB's contract. This report is used to determine the IEB's compliance with one of the Administrative Authority and Level of Care performance measures.** **3. OPS-104, Fiscal/Employer Agent (F/EA) Waiver Assurance Monitoring Report – a standard monthly report which outlines the eight key requirements as defined in the F/EA's contract.** **4. Pennsylvania Individualized Assessment (PIA) reports – a standard monthly report that documents the results of OLTL's initial functional eligibility frequency determinations conducted by Aging Well.** **5. Retrospective Service Plan Review Report – a standardized report used by the BQAPA to capture the results from the Retrospective Service Plan Review process. This review evaluates whether Individual Service Plans (ISPs) are person-centered and inclusive of all of the assessed needs of the individual.** **6. The Provider Enrollment Database and Provider Reimbursement and Operations Management Information System (PROMISe™) Intranet Extract reports – these reports are used to verify that newly enrolled providers meet the licensure/certification requirements and/or the established standards to be enrolled as a Medicaid waiver provider. These reports are also used to verify that providers continue to meet the established requirements. PROMISe™ Intranet Extract reports are also used to verify the accuracy of provider rates and claim payments. Note: PROMISe™ is OLTL's CMS certified Medicaid Management Information System (MMIS).** **7. Participant Review Tool (PRT) – a standardized participant review tool conducted by the participant's SC that is designed to capture information on participants' health, welfare, and service needs in all HCBS settings on an annual basis. The**	

	discuss strategies for mitigation and the appropriate bureau or division follows up with the entity and discusses the steps needed to bring them into compliance including (if needed) technical assistance from OLTL. Compliance with the assurance is then monitored closely to ensure the performance measure rate increases. If the performance measure rate does not increase, the process begins again until the compliance rate increases to the acceptable level of 86% as established by CMS. The continued improvement of performance measure compliance rates beyond 86% is pursued. Whenever possible OLTL strives to establish systems that achieve 100% performance measure compliance rates. OLTL distributes information internally through various meetings comprised of OLTL Bureau Directors, Division Directors, and/or designees, SMEs as well as other OLTL staff pertinent to the discussion. Information related to the performance measures is shared and if needed remediation is discussed for achieving targeted goals. OLTL provides data as requested to providers, participants and other stakeholders and interested parties. Results from the Participant Satisfaction Survey are posted on the DHS website 3 times per year. Results from provider monitoring are communicated to providers as soon as possible after the monitoring takes place. *** The Director reviews and provides input on the identification and collection of all data to be used in reports and what may be shared with the Medical Assistance Advisory Committee (MAAC) and the Consumer Subcommittee of the MAAC.	**overall goal of the tool is to assist SCs in their role of improving the experience of care for participants and provides excellent opportunities for SCs to address participant's concerns.** **8. Enterprise Incident Management (EIM) reports – a standardized report generated from the electronic Enterprise Incident Management system (EIM), an electronic data system that collects information regarding critical incidents involving waiver participants. The Bureau of Coordinated and Integrated Services (BCIS) reviews reports generated in EIM to track and trend critical incidents and identify patterns and concerns regarding how the incidents are processed, investigated, and remediated.** **9. Quality Management Efficiency Teams (QMETs) Provider Database – a database used by QMETs to capture LTSS provider and Service Coordination Entity (SCE) monitoring information such as previous and upcoming monitoring visit dates, monitoring visit findings, Corrective Action Plan (CAP) status, and follow up actions.** **Onsite Paid Claims Report – a standardized report generated from the Enterprise Data Warehouse to identify claims for paid providers. The report is loaded to the QMET Provider Database for use in validating type, scope, amount, duration and frequency and number of units billed.** ~~Administrative Authority Assurance: Six Performance Measures~~ ~~• Level of Care Determination Report - Annually~~ ~~• Independent Enrollment Broker Contractual Obligation Report - Quarterly~~ ~~• Initial and Annual Level of Care Report - Annually~~ ~~• Qualified Provider Report - Quarterly~~ ~~Level of Care Assurance: Two Performance Measures~~ ~~• Annual Level of Care Report - Annually~~ ~~• Initial Level of Care Report - Annually~~	

		~~Qualified Provider Assurance: Five Performance Measures~~ ~~• Qualified Provider Report - Quarterly~~ ~~• Initial Provider Enrollment Report - Quarterly~~ ~~Service Plan Assurance: Eight Performance Measures~~ ~~• Service Plan Assurance Data Report - Annually~~ ~~• Participant Satisfaction Survey Results - 3 times per year~~ ~~• QMET Report on Service Delivery - Quarterly • Enterprise Incident Management (EIM) Report on Complaints - Monthly/On Demand~~ ~~Health and Welfare Assurance: Fourteen Performance Measures~~ ~~• EIM Reports on Complaints and Incidents - Monthly/On Demand~~ ~~• Participant Satisfaction Survey Reports - 3 times per year~~ ~~• Service Plan Assurance Data Report - Annually~~ ~~Financial Accountability Assurance: Five Performance Measures~~ ~~• Onsite Paid Claims Report - Quarterly~~ ~~• PROMISe Paid Claims Report - Annually~~ ~~• PROMISe Claims/Rate Setting and Payment Report – Annually~~ **Supporting vendors submit data to OLTL using OPS-100, OPS-101, OPS-102, and internal reports, such as the Provider Enrollment Database report, PROMISe™ Intranet Extract report, and EIM reports, are pulled and reviewed by the by OLTL Subject Matter Experts (SMEs) located in the corresponding bureau responsible for oversight of the assurance. The SMEs findings are reviewed by the Divisions' Quality Management Liaisons to ensure they are complete, accurate, consistent, and reliable; identify whether the 86% compliance threshold for the performance measure is met; identify whether a Quality Improvement Project (QIP) was initiated when a performance measure is noncompliant; identify whether all cases of noncompliance have been remediated; and monitor the timeliness of remediation. When deficiencies or instances of noncompliance are found, the Quality Management Liaison and**	

		SMEs discuss the issue and strategies for mitigation; the SME follows up with the appropriate entity and provides technical assistance that focuses on helping the entity come into compliance with program policies and regulations. **Areas of noncompliance are shared and reviewed internally with OLTL Bureau Directors, Division Directors and/or their designees, SMEs and other OLTL staff pertinent to discuss any necessary follow-up actions. When the deficiency is significant or ongoing, the supporting vendor or direct service provider may be required to develop a CAP. The plan must include methods for remedying the areas of deficiency including timeframes to complete the actions. CAPs must be submitted to OLTL for approval within 15 working days of the request. OLTL reviews and approves the CAP within 30 working days of submission. OLTL monitors plan implementation to determine if the area of deficiency has been corrected within the established timeframes. If the deficiency has not been corrected, the supporting vendor or direct service provider will receive additional technical assistance and, in some cases, a new CAP will be requested, or financial sanctions will be imposed.** ~~After completing their reports, OLTL SMEs provide the Division of Quality Assurance with the data for the performance measures. The performance measures obtained are reviewed by the Division of Quality Assurance. Data is analyzed and reviewed for each waiver assurance to ensure the reports and performance measures collected are valid. If non-compliance or low compliance is identified, the bureaus and divisions in OLTL discuss strategies for mitigation and the appropriate bureau or division follows up with the entity and discusses the steps needed to bring them into compliance including (if needed) technical assistance from OLTL. Compliance with the assurance is then monitored closely to ensure the performance measure rate increases. If the performance measure rate does not increase, the process begins again until the compliance rate~~	

		~~increases to the acceptable level of 86% as established by CMS. The continued improvement of performance measure compliance rates beyond 86% is pursued. Whenever possible OLTL strives to establish systems that achieve 100% performance measure compliance rates.~~ ~~OLTL distributes information internally through various meetings comprised of OLTL Bureau Directors, Division Directors, and/or designees, SMEs as well as other OLTL staff pertinent to the discussion. Information related to the performance measures is shared and if needed remediation is discussed for achieving targeted goals. OLTL provides data as requested to providers, participants and other stakeholders and interested parties. Results from the Participant Satisfaction Survey are posted on the DHS website 3 times per year. Results from provider monitoring are communicated to providers as soon as possible after the monitoring takes place.~~ *** The Director reviews and provides input on the identification and collection of all data to be used in reports and what may be shared with the Medical Assistance Advisory Committee (MAAC) and the **Long-Term Services and Supports and** Consumer Subcommittee**s** of the MAAC.	
Appendix H-1(b)	For the two year review, the Division of Quality Assurance will review the waiver assurance's performance measures and discovery and remediation functions, and will make changes when necessary. The Division of Quality Assurance will review the Improvement Strategy and comments/recommendations from the SMEs.	For the ~~two year~~ **two-year** review, the ~~Division of Quality Assurance~~ **DQA** will review the waiver assurance's performance measures and discovery and remediation functions, and will make changes when necessary. The ~~Division of Quality Assurance~~ **DQA** will review the Improvement Strategy and comments/recommendations from the SMEs.	Updated abbreviations and removed an expired web address.
Appendix I-1	See 55 PA Code Chapter §52.43 at the following link: http://www.pacode.com/secure/data/055/chapter52/055_0052.pdf ***	See 55 PA Code Chapter §52.43. ~~at the following link: http://www.pacode.com/secure/data/055/chapter52/055_0052.pdf~~ ***	Removed outdated web address and updated Division name.

	When overpayments, or payments unsupported by proper documentation are identified during monitoring, the following steps are taken by the Division of Provider and Operations Management.	When overpayments, or payments unsupported by proper documentation are identified during monitoring, the following steps are taken by the Division of Provider ~~and~~ Operations ~~Management~~.	
Appendix I-2(a)	The link to OLTL's current rate schedule can be found on the following web page under OLTL Home and Community-Based Services Regulations and Rates, MA Fee Schedule Rates: http://www.dhs.pa.gov/provider/longtermcareprov/ Please refer to the following link for a description of the regions and a summary of the rate-setting methodology: http://www.pabulletin.com/secure/data/vol42/42-23/1058.html. *** Rates for the following services are on the waiver fee schedule: Adult Daily Living Services (Basic and Enhanced), Behavior Therapy, Benefits Counseling, Career Assessment, Cognitive Rehabilitation Therapy, Community Integration, Counseling Services, Employment Skills Development, Home Health Services (Nursing, Occupational Therapy, Physical Therapy and Speech and Language Therapy), Job Coaching, Job Finding, Nutritional Consultation, Personal Assistance Services (agency and participant-directed), Personal Assistance Services – participant-directed overtime, Prevocational Services, Residential Habilitation, Residential Habilitation Enhanced staffing, Respite (agency and participant-directed), Respite – participant-directed overtime, Service Coordination, Structured Day Habilitation, and Structured Day Habilitation Enhanced Staffing. *** The State acknowledges that the populations in need of care are projected to grow rapidly and the need for a robust, skilled, and dedicated direct care workforce is more important than ever. The turnover rate for direct care workers is estimated at 44-65%	The link to OLTL's current rate schedule can be found on the following web page under OLTL Home and Community-Based Services Regulations and Rates, MA Fee Schedule Rates: ~~http://www.dhs.pa.gov/provider/longtermcareprov/~~ **https://www.pa.gov/agencies/dhs/resources/for-providers/ltc-providers.html** Please refer to the following ~~link~~ **notice in the Pennsylvania Bulletin** for a description of the regions and a summary of the rate-setting methodology: **42 Pa.B. 3343 (June 9, 2012)** ~~http://www.pabulletin.com/secure/data/vol42/42-23/1058.html.~~ *** Rates for the following services are on the waiver fee schedule: Adult Daily Living Services (Basic and Enhanced), Behavior Therapy, Benefits Counseling, Career Assessment, Cognitive Rehabilitation Therapy, Community Integration, Counseling Services, Employment Skills Development, Home Health Services (Nursing, Occupational Therapy, Physical Therapy and Speech and Language Therapy), Job Coaching, Job Finding, Nutritional Consultation, Personal Assistance Services (agency and participant-directed), Personal Assistance Services – participant-directed overtime, ~~Prevocational~~ **Employment** Services **(Benefits Counseling, Career Assessment, Employment Skills Development, Job Coaching and Job Finding),** Residential Habilitation, Residential Habilitation Enhanced staffing, Respite (agency and participant-directed), Respite – participant-directed overtime, Service Coordination, Structured Day Habilitation, and Structured Day Habilitation Enhanced Staffing. *** ~~The State acknowledges that the populations in need of care are projected to grow rapidly and the need for a robust, skilled, and~~	Removed and updated outdated language.

	each year and the number one contributing factor for this turnover rate is low wages. Therefore, the State modeled a wage increase, and 2% was assessed to be successful in providing an increase in wages to direct care staff in order to ensure continued access while also remaining within the parameters of the budget appropriations. OLTL provides stakeholders and the general public input on rates in a variety of ways. Feedback is solicited through various forums, including convening a provider workgroup, conducting on-site provider interviews, issuing an all-provider survey, and providing updates at the Long-Term Care Subcommittee of the Medical Assistance Advisory Committee (MAAC). Staff then reviews the participant files for the individualized assessment which was performed determining the participants need, and contact notes in HCSIS or SAMS to verify that the service approved was provided. Non-Medical Transportation services cannot be authorized for a participant that is receiving Residential Habilitation services. The Bureau of Participant Operations ensures that both Residential Habilitation and Non-Medical Transportation are not mutually present on service plans at time of review. BPO also performs random reviews of those ISPs that go through the auto approval process.	~~dedicated direct care workforce is more important than ever. The turnover rate for direct care workers is estimated at 44-65% each year and the number one contributing factor for this turnover rate is low wages. Therefore, the State modeled a wage increase, and 2% was assessed to be successful in providing an increase in wages to direct care staff in order to ensure continued access while also remaining within the parameters of the budget appropriations.~~ OLTL provides stakeholders and the general public input on rates in a variety of ways. Feedback is solicited through various forums, including convening a provider workgroup, conducting on-site provider interviews, issuing an all-provider survey, and providing updates at the Long-Term ~~Care~~ **Services and Supports (LTSS)** Subcommittee of the Medical Assistance Advisory Committee (MAAC). *** Staff then reviews the participant files for the individualized assessment which was performed determining the participants need, and contact notes in HCSIS ~~or SAMS~~ to verify that the service approved was provided. Non-Medical Transportation services cannot be authorized for a participant that is receiving Residential Habilitation services. The Bureau of ~~Participant Operations~~ **Fee for Service Programs (BFFSP)** ensures that both Residential Habilitation and Non-Medical Transportation are not mutually present on service plans at time of review. ~~BPO~~ **BFFSP** also performs random reviews of those ISPs that go through the auto approval process.	
Appendix I-2(d)	All unsupported overpaid claims identified by the TSADF review are reported to the Division of Provider and Operations Management for recoupment purposes.	All unsupported overpaid claims identified by the TSADF review are reported to the Division of ~~Provider and~~ **Fee for Service** Operations ~~Management~~ for recoupment purposes.	Updated to correct division name.
Main Module Attachment 2	Attachment 2 removed from waiver as HCBS Settings Rule has been integrated into the waiver.	Attachment 2 removed from waiver as HCBS Settings Rule has been integrated into the waiver.	

Appendix A Quality Improvement: Administrative Authority	AA-2 Number and percent of Service Coordination Entities (SCEs) that conduct the annual redetermination of level of care within the required timeframe Numerator: Number of SCEs reviewed that conduct the annual redetermination of level of care within the required timeframe Denominator: Total number of SCEs reviewed Frequency of data collection: Biennially	AA-2 Number and percent of Service Coordination Entities (SCEs) that conduct the annual redetermination of level of care within the required timeframe Numerator: Number of SCEs reviewed that conduct the annual redetermination of level of care within the required timeframe Denominator: Total number of SCEs reviewed **who actively bill** Frequency of data collection: ~~Biennially~~ **Annually**	Modify performance measure AA-2 to clarify denominator and change frequency of data collection from biennially to annually.
Appendix A(a)(ii) - Quality Improvement: Administrative Authority	The Quality Management Efficiency Teams (QMETs) are the State Medicaid Agency's (OLTL) regional provider monitoring agents. The QMETs are comprised of one Program Specialist (regional team lead), one Registered Nurse, one Social Worker, and one Fiscal Agent. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator. Using a standard monitoring tool which outlines the provider qualifications as listed in the waiver, the QMET verify that the provider continues to meet each requirement during the review. During the provider review, a random sample of employee and consumer records are reviewed to ensure compliance with waiver standards. Each provider will be reviewed every two years, at minimum. Additionally, QMET conduct remediation activities as outlined in the waiver application. The Bureau of Quality Assurance and Program Analytics (BQAPA) reviews AAAs regarding the initial LOC, reevaluations of LOC, F/EA and enrollment functions. The BQAPA uses standard monitoring tools which outline the provider requirements as listed in the waiver and the F/EA contract, including LOC determination, F/EA, and enrollment functions. The BQAPA verifies that the LOC determination, F/EA, and enrollment requirements continue to be met during the reviews. During the	~~The Quality Management Efficiency Teams (QMETs) are the State Medicaid Agency's (OLTL) regional provider monitoring agents. The QMETs are comprised of one Program Specialist (regional team lead), one Registered Nurse, one Social Worker, and one Fiscal Agent. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator. Using a standard monitoring tool which outlines the provider qualifications as listed in the waiver, the QMET verify that the provider continues to meet each requirement during the review. During the provider review, a random sample of employee and consumer records are reviewed to ensure compliance with waiver standards. Each provider will be reviewed every two years, at minimum. Additionally, QMET conduct remediation activities as outlined in the waiver application.~~ ~~The Bureau of Quality Assurance and Program Analytics (BQAPA) reviews AAAs regarding the initial LOC, reevaluations of LOC, F/EA and enrollment functions. The BQAPA uses standard monitoring tools which outline the provider requirements as listed in the waiver and the F/EA contract, including LOC determination, F/EA, and enrollment functions. The BQAPA verifies that the LOC determination, F/EA, and enrollment requirements continue to be met during the reviews. During the AAA review, random samples of consumer records are reviewed to ensure compliance with waiver LOC determination standards. Each AAA will be reviewed every two years, at minimum.~~ ~~The State will follow the sampling methods and timelines as outlined~~	Revised language regarding the methods OLTL uses to assess the performance of contracted entities to ensure they perform their designated activities as required. The previous language was outdated.

	AAA review, random samples of consumer records are reviewed to ensure compliance with waiver LOC determination standards. Each AAA will be reviewed every two years, at minimum. The State will follow the sampling methods and timelines as outlined in the waiver specific transition plan. For information regarding the BQAPA and the Quality Improvement Strategy, please refer to Appendix H for detailed information.	~~in the waiver specific transition plan.~~ ~~For information regarding the BQAPA and the Quality Improvement Strategy, please refer to Appendix H for detailed information.~~ **OLTL contracts with the following entities which perform waiver operational and administrative functions on behalf of the Medicaid agency:** **1. Aging Well PA, LLC (Aging Well) serves as the IAE. Aging Well is responsible for conducting the initial functional eligibility determinations for all individuals applying for LTSS. Aging Well is required to assess enrollees within 10 business days of receiving the request from the IEB as outlined in OLTL Medical Assistance Bulletin #IEB-19-04, IAE-19-04, 07-19-04, Implementation of the Functional Eligibility Determination Process. Aging Well is also responsible for ensuring that functional eligibility determinations are completed in accordance with established policies and procedures.** **2. Maximus serves as the Independent Enrollment Broker for all OLTL LTSS programs. Maximus is responsible for facilitating waiver enrollment activities, including educating enrollees on LTSS, referring the individual to the IAE for their clinical eligibility determination, obtaining the physician certification from the enrollee's PCP, and assisting the enrollee with completing the financial eligibility determination paperwork.** **3. PPL serves as the Vendor Fiscal/Employer Agent (F/EA) for the OBRA waiver. PPL is responsible for supporting waiver participants in their role as the common-law employer of their direct care workers. Specifically, PPL's responsibilities included providing orientation and training to participants, conducting background checks as required in policy, processing time worked and issuing direct care workers' payroll checks, withholding and filing federal, state and**	

		local taxes, brokering workers' compensation insurance, and providing monthly financial reports to the participant. **4. OLTL delegates the annual redetermination of level of care to OBRA Service Coordinators (SCs) with OLTL oversight. These SCs, employed by MA enrolled Service Coordination Entities, conduct the annual redeterminations of functional eligibility for participants that are already enrolled in the waiver. SCs may conduct reevaluations more frequently, if needed.** **Administration and oversight of these external entities falls within the purview of OLTL and DHS. The following Bureaus within OLTL are responsible for monitoring and assessing the on-going performance of the above-referenced contracted entities.** • **BCIS oversees the daily administrative operations and provides ongoing monitoring of the performance of the IEB and the IAE.** • **The Bureau of Fee for Service Programs (BFFSP) oversees and monitors the performance of the F/EA.** • **The QMETs, located within the BFFSP, conduct onsite visits of enrolled OBRA Waiver SCEs every two years to monitor compliance with annual redetermination of functional eligibility. Where indicated, representative sample sizes for each measure is determined by using the Raosoft® Sample Size Calculator, the population size, and the 5% error/95% confidence/50% distribution levels to identify the appropriate sample size.**	
Appendix A(b)(i) Quality Improvement: Administrative Authority	When the administrative data and QMET monitoring reviews identify AAAs or SCAs that are not meeting the requirements related to Level of Care determinations as outlined in the waiver agreement, the agency receives written notification of outstanding issues with a request for a Corrective Action Plan (CAP). The CAP is due to the QMET within 15 working days. BQAPA staff reviews and accepts/rejects the CAP within 30	~~When the administrative data and QMET monitoring reviews identify AAAs or SCAs that are not meeting the requirements related to Level of Care determinations as outlined in the waiver agreement, the agency receives written notification of outstanding issues with a request for a Corrective Action Plan (CAP). The CAP is due to the QMET within 15 working days. BQAPA staff reviews and accepts/rejects the CAP within 30 working days. Monitoring by the~~	Revised language regarding the methods OLTL uses to assess the performance of contracted entities to ensure they perform their designated activities as required. The previous language was outdated.

	working days. Monitoring by the QMET occurs to ensure the CAP 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, technical assistance is provided by BQAPA. Through a combination of reports from the enrollment broker and administrative data, the Contract Monitor for the Independent Enrollment Broker (IEB) determines if the contractual obligations are being met. If they are not met, Bureau of Fee for Service Programs (BFFSP) notifies the IEB agency of the specific deficiencies, requests a corrective action plan and follows-up on the plan to ensure compliance. Through a combination of reports from the F/EA and administrative data, the Contract Monitor for the Fiscal/Employer Agent determines if the contractual obligations are being met. If they are not met, BFFSP notifies the F/EA of the specific deficiencies, requests a corrective action plan and follows-up on the plan to ensure compliance	~~QMET occurs to ensure the CAP 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, technical assistance is provided by BQAPA.~~ ~~Through a combination of reports from the enrollment broker and administrative data, the Contract Monitor for the Independent Enrollment Broker (IEB) determines if the contractual obligations are being met. If they are not met, Bureau of Fee for Service Programs (BFFSP) notifies the IEB agency of the specific deficiencies, requests a corrective action plan and follows-up on the plan to ensure compliance.~~ ~~Through a combination of reports from the F/EA and administrative data, the Contract Monitor for the Fiscal/Employer Agent determines if the contractual obligations are being met. If they are not met, BFFSP notifies the F/EA of the specific deficiencies, requests a corrective action plan and follows-up on the plan to ensure compliance.~~ **When deficiencies or instances of noncompliance are found, the Quality Management Liaison and SMEs discuss the issue and strategies for mitigation; the SME follows up with the appropriate entity and provides technical assistance that focuses on helping the entity come into compliance with program policies and regulations.** **Areas of noncompliance are shared and reviewed internally with OLTL Bureau Directors, Division Directors and/or their designees, SMEs and other OLTL staff pertinent to discuss any necessary follow-up actions. When the deficiency is significant or ongoing, the supporting vendor or direct service provider may be required to develop a Corrective Action Plan (CAP). The CAP must include methods for remedying the areas of deficiency including timeframes to complete the actions. CAPs must be submitted to**	

		OLTL for approval within 15 working days of the request. OLTL reviews and approves the CAP within 30 working days of submission. OLTL monitors plan implementation to determine if the area of deficiency has been corrected within the established timeframes. If the deficiency has not been corrected, the supporting vendor or direct service provider will receive additional technical assistance and, in some cases, a new CAP will be requested, or financial sanctions will be imposed.	
Appendix B(a)(ii) Quality Improvement: Level of Care	The Level of Care Sub-assurances are monitored through representative data sampling of specific information that forms the numerator, denominator and parameters for the performance measure as defined by the Department. The Bureau of Quality Assurance and Program Analytics (BQAPA) is responsible for review and analysis of the report information. Reports are received from case management systems and from a compilation of the results of retrospective service plan reviews. The LOC Assurance Liaison, within OLTL's BQAPA, regularly reviews reports on a semi-annual basis regarding the completion of initial level of care prior to the receipt of waiver services. Quarterly reports are reviewed for compliance with waiver standards with processes and instruments for initial LOC. Monthly reports from the Service Plan retrospective review database are reviewed by the LOC Liaison regarding the timeliness of LOC reevaluations. See Appendix D for more information about retrospective service plan reviews and Appendix H for more information about Assurance Liaisons. Additional information on the BQAPA can be found in Appendix H.	The Level of Care Sub-assurance**s ~~are~~ is** monitored through representative data sampling of specific information that forms the numerator, denominator and parameters for the performance measure as defined by the Department. **An individual's level of care is determined through an assessment of the individual's need for services and a physician certification. DHS contracts with Aging Well as the IAE; in turn, Aging Well contracts with the 52 local Area Agencies on Aging to conduct the initial clinical assessments. Assessors must perform the initial assessment in person and are required to assess the individual within 10 business days of receiving a request for an assessment through the PIA computer system. The request may be entered into PIA by the IEB or by another appropriate referral source that has access to PIA.** **Assessors use a standardized assessment tool, known as the FED, to determine an individual's disability, age of onset and functional limitations, need for active treatment, medical/nursing needs, and whether the individual is at risk for placement into an institution in the absence of waiver services. This standardized assessment is documented in PIA. A physician must also certify all functional eligibility determinations. In instances where the certification submitted by the individual's physician and the assessor's opinion differs from the outcome of the FED, OLTL's Medical Director**	Revised language regarding the methods OLTL uses to assess the performance of contracted entities to ensure they perform their designated activities as required. The previous language was outdated.

		reviews all available documentation and makes the final determination. ~~The Level of Care Sub-assurances are monitored through representative data sampling of specific information that forms the numerator, denominator and parameters for the performance measure as defined by the Department. The Bureau of Quality Assurance and Program Analytics (BQAPA) is responsible for review and analysis of the report information. Reports are received from case management systems and from a compilation of the results of retrospective service plan reviews. The LOC Assurance Liaison, within OLTL's BQAPA, regularly reviews reports on a semi-annual basis regarding the completion of initial level of care prior to the receipt of waiver services. Quarterly reports are reviewed for compliance with waiver standards with processes and instruments for initial LOC. Monthly reports from the Service Plan retrospective review database are reviewed by the LOC Liaison regarding the timeliness of LOC reevaluations. See Appendix D for more information about retrospective service plan reviews and Appendix H for more information about Assurance Liaisons.~~ ~~Additional information on the BQAPA can be found in Appendix H.~~	
Appendix B(b)(i) Quality Improvement: Level of Care	If the BQAPA's review of LOC data in the case management or Retrospective Service Plan Review tracking systems identifies non-compliance regarding the timeliness or specifications of initial or annual LOC reassessments, a Quality Improvement Plan (QIP) is requested from BFFSP. More information on QIPs can be found in Appendix H.	**Aging Well is responsible for the validity of the assessments and must have procedures in place to review the assessments and to ensure that the assessments are sound and conducted correctly. Using OPS-101 and OPS-102, BCIS monitors the performance of Aging Well and Maximus to confirm that all new enrollees who have a functional eligibility determination completed prior to the receipt of waiver services and that assessments were performed according to established policies and procedures. In addition, the OLTL Medical Director and a clinical team comprised of Registered Nurses (RNs) complete a clinical review of a sample of applicants that are determined ineligible for an ICF/ORC to ensure oversight of the assessment process.**	Revised language regarding the methods OLTL uses to assess the performance of contracted entities to ensure they perform their designated activities as required. The previous language was outdated.

		OBRA Waiver SCEs are responsible for conducting the annual redetermination of functional eligibility using OLTL's standardized needs assessment. OLTL ensures that the annual redetermination process is completed on time and consistent with OLTL policies through the retrospective review of valid statistical sample of service plans and onsite monitoring of the SCEs. **Data is submitted to OLTL using the above referenced reports and their corresponding instructions, where it is retrieved by subject matter experts (SMEs). SMEs have been trained to review the data to ensure it is complete, accurate, consistent, and reliable, and follow-up with the supporting vendors as necessary; identify whether the supporting vendor meets the 86% compliance threshold for the performance measure; identify whether a Quality Improvement Project (QIP) was initiated when a performance measure is non-compliant; identify whether all cases of non-compliance have been remediated; and monitor the timeliness of remediation.** **When deficiencies or instances of noncompliance are found, the Quality Management Liaison and SMEs discuss the issue and strategies for mitigation; the SME follows up with the appropriate entity and provides technical assistance that focuses on helping the entity come into compliance with program policies and regulations.** **Areas of noncompliance are shared and reviewed internally with OLTL Bureau Directors, Division Directors and/or their designees, SMEs and other OLTL staff pertinent to discuss any necessary follow-up actions. When the deficiency is significant or ongoing, the supporting vendor or direct service provider may be required to develop a CAP. The plan must include methods for remedying the areas of deficiency, including timeframes to complete the actions. CAPs must be submitted to OLTL for approval within 15 working days of the request. OLTL reviews and approves the CAP within 30**	

		working days of submission. OLTL monitors plan implementation to determine if the area of deficiency has been corrected within the established timeframes. If the deficiency has not been corrected, the supporting vendor or direct service provider will receive additional technical assistance and, in some cases, a new CAP will be requested, or financial sanctions will be imposed. ~~If the BQAPA's review of LOC data in the case management or Retrospective Service Plan Review tracking systems identifies non-compliance regarding the timeliness or specifications of initial or annual LOC reassessments, a Quality Improvement Plan (QIP) is requested from BFFSP. More information on QIPs can be found in Appendix H.~~	
Appendix C Quality Improvement: Qualified Providers	QP-2: Number and percent of enrolled licensed/certified waiver providers who continue to meet applicable licensure/certification, regulatory and applicable waiver standards following initial enrollment Numerator: Number of providers who continue to meet required licensure and initial QP standards Denominator: Number of providers reviewed	QP-2: Number and percent of enrolled licensed/certified waiver providers who continue to meet applicable licensure/certification, regulatory and applicable waiver standards following initial enrollment Numerator: Number of **enrolled** providers who continue to meet required licensure and initial QP standards Denominator: Number of providers reviewed	Clarify numerator is enrolled providers.
Appendix C(a)(ii) Quality Improvement: Qualified Providers	The Quality Management Efficiency Teams (QMETs) are OLTL's regional provider monitoring agents. The QMETs monitor providers of direct services as well as agencies having delegated functions. Each regional QMET is comprised of a Program Specialist (regional team lead), Registered Nurses, Social Workers, and Fiscal Representatives. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator. The Quality Management Efficiency Teams (QMETs) monitor the HCBS Waiver providers on a biennial basis. The QMET utilizes a standardized monitoring tool for each monitoring, and monitors providers against standards derived from Title 55, Chapter 52 of the Pennsylvania Code and the provider requirements of the established, approved waivers. QMET also reviews if the	**In order for providers to participate as a Medicaid waiver provider, they must first enroll with DHS. As part of the enrollment application process, providers in Pennsylvania must provide written documentation that demonstrates the provider meets all state licensing and certification requirements, as well as all other conditions that are not part of licensure or certification. Out-of-state providers must also provide documentation that they participate in their state's Medicaid and/or CHIP program.** **BFFSP is responsible for verifying that each provider meets the established licensing and certification standards and possesses the necessary skills, competencies, and qualifications prior to enrollment and prior to the provision of services to OBRA waiver participants. When enrollment applications are received, Bureau staff review the applications for accuracy and completeness using a**	Revised language regarding the methods OLTL uses to assess the performance and quality of waiver service providers. The previous language was outdated.

	provider has the appropriate licensure as required by the waiver. QMET reviews each provider at a 95% accuracy rating for each waiver in which the provider is enrolled	**standardized enrollment checklist, and follow-up with providers where information or documentation is missing. If the provider does not respond within 30 days of a final request for missing or incorrect information/ documentation, OLTL denies the application. Applications are not approved until the provider meets all applicable federal and state requirements for the waiver.** **Using reports from the Provider Enrollment Database and a PROMISe™ Intranet Extract, BFFSP verifies that newly enrolled providers meet the licensure/certification requirements and/or the established standards to be enrolled as a Medicaid waiver provider. BFFSP uses the same reports to verify that providers continue to meet the established requirements. These reports are used to evaluate compliance with performance measures QP-1 and QP-5 below.** **The QMETs perform a comprehensive onsite monitoring of actively billing HCBS providers every two years. The monitoring schedule is developed based on geographic location, provider size and staffing. Onsite reviews can take approximately one to two days; however, this could vary depending upon the findings and availability of information during the monitoring. Using a standardized, web-based monitoring tool and online database, the QMETs verify that providers, both those who require licensure and/or certification and those that do not, continue to meet the applicable waiver standards following initial enrollment. The QMETs also monitor provider compliance with the new provider training requirements. This onsite monitoring is used to evaluate compliance with QP-2, QP-6, and QP-7.** ~~The Quality Management Efficiency Teams (QMETs) are OLTL's regional provider monitoring agents. The QMETs monitor providers of direct services as well as agencies having delegated functions. Each regional QMET is comprised of a Program Specialist (regional team lead), Registered Nurses, Social Workers, and Fiscal~~	

		~~Representatives. Five teams are dispersed throughout the state of Pennsylvania, and report directly to the OLTL QMET State Coordinator. The Quality Management Efficiency Teams (QMETs) monitor the HCBS Waiver providers on a biennial basis. The QMET utilizes a standardized monitoring tool for each monitoring, and monitors providers against standards derived from Title 55, Chapter 52 of the Pennsylvania Code and the provider requirements of the established, approved waivers. QMET also reviews if the provider has the appropriate licensure as required by the waiver. QMET reviews each provider at a 95% accuracy rating for each waiver in which the provider is enrolled.~~	
Appendix C(b)(i) Quality Improvement: Qualified Providers	Subassurance a.i.a - Before a provider is enrolled as a qualified waiver provider, it must provide written documentation to the State Medicaid Agency (OLTL) of all state licensing and certification requirements. Additionally, a licensed or certified provider is required to submit written documentation that it meets regulatory and initial qualified waiver requirements that are not part of its licensure or certification. When OLTL discovers an applicant provider does not meet licensure or certification requirements, the provider is not enrolled to provide services until the appropriate license or certification is obtained. When it is discovered that an existing provider is enrolled as a waiver provider, but has not obtained appropriate certification or licensure, OLTL issues a Statement of Findings as required by 55 Pa. Code Chapter 52. The provider is required to respond to the findings with a Corrective Action Plan (CAP) to remediate each finding. If a provider fails to submit a CAP which remediates the lack of licensure or certification requirement, OLTL begins disenrollment proceedings. The provider has the right to appeal. Subassurance a.i.b- Upon application, OLTL reviews verification submitted by providers who are not required to receive a	~~Subassurance a.i.a -~~ Before a provider is enrolled as a qualified waiver provider, it must provide written documentation to the State Medicaid Agency (OLTL) of all state licensing and certification requirements. Additionally, a licensed or certified provider is required to submit written documentation that it meets regulatory and initial qualified waiver requirements that are not part of its licensure or certification. **Compliance/noncompliance with the established licensing and certification standards and submission of all other required information is documented in the Provider Enrollment Access Database. Once the application has been approved, the provider is entered into PROMISe™, DHS' Medicaid Management Information System (MMIS). Should OLTL receive notification from the licensing body that the provider lost their license/certification or become aware of damaging audit results from DHS' Bureaus of Financial Operations (BFO) or Program Integrity (BPI), OLTL will follow-up and may terminate a provider's enrollment as warranted. Provider's credentials are revalidated every five years from the date of the previous validation.** **If a provider fails to submit their paperwork for revalidation, PROMISe™ will end date their provider number. Once a provider is end dated, SCs will receive an alert in the Home and Community**	Revised language regarding the methods OLTL uses to assess the performance and quality of waiver service providers. The previous language was outdated.

	license or certification in order to provide services. OLTL verifies each provider meets the established regulations and criteria to be a qualified waiver provider. If a provider does not meet one or more of the waiver qualifications, OLTL notifies the provider of the unmet qualifications and provide information on available resources the provider can access to improve or develop internal systems to meet required provider qualifications. If a provider is unable to meet qualifications, the application to provide waiver services is denied. The provider may reapply with OLTL if verification is obtained. Within two years of becoming a waiver provider (and every two years thereafter), OLTL conducts a provider monitoring of each waiver provider to ascertain whether they continue to meet the regulatory requirements and provider qualifications, including training, outlined in this waiver. The Quality Management Efficiency Teams (QMETs) are the monitoring agent for OLTL. The QMET monitoring tool and database outlines each qualification a provider must meet. The qualifications are categorized according to provider type. Provider type is defined as the service(s) the provider offers to waiver participants as outlined in the service definition. The QMET monitoring tool and database collects the information discovered by the QMETs during reviews for data analysis and aggregation purposes. Through this process, if a QMET discovers a provider does not meet one or more of the qualifications, the provider develops a Corrective Action Plan (CAP). The provider needs to demonstrate through the CAP that it can meet the regulations and waiver provider qualifications and develop a process on how to continue compliance in the future. The provider has 15 business days to submit a completed CAP to the appropriate	**Services Information System (HCSIS), OLTL's case management system. SCs are not able to add the provider to the participant's ISP and work to transition participants using an end dated provider to a new provider.** ~~When OLTL discovers an applicant provider does not meet licensure or certification requirements, the provider is not enrolled to provide services until the appropriate license or certification is obtained. When it is discovered that an existing provider is enrolled as a waiver provider, but has not obtained appropriate certification or licensure, OLTL issues a Statement of Findings as required by 55 Pa. Code Chapter 52. The provider is required to respond to the findings with a Corrective Action Plan (CAP) to remediate each finding. If a provider fails to submit a CAP which remediates the lack of licensure or certification requirement, OLTL begins disenrollment proceedings. The provider has the right to appeal.~~ ~~Subassurance a.i.b- Upon application, OLTL reviews verification submitted by providers who are not required to receive a license or certification in order to provide services. OLTL verifies each provider meets the established regulations and criteria to be a qualified waiver provider. If a provider does not meet one or more of the waiver qualifications, OLTL notifies the provider of the unmet qualifications and provide information on available resources the provider can access to improve or develop internal systems to meet required provider qualifications. If a provider is unable to meet qualifications, the application to provide waiver services is denied. The provider may reapply with OLTL if verification is obtained.~~ Within two years of becoming a waiver provider (and every two years thereafter), OLTL conducts a provider monitoring of each waiver provider to ascertain whether they continue to meet the regulatory requirements and provider qualifications, including	

	regional QMET, and OLTL reviews and approves (or disapproves) the CAP within 30 business days of submission. The QMET verifies the approved CAP action steps are in place according to the timeframe as written the CAP. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP. If the provider is unable or unwilling to develop a CAP which addresses and remediates each of the findings, OLTL takes action against the provider up to and including disenrollment. The provider has the right to appeal. Subassurance a.i.c- The QMET monitoring tool ascertains if the provider has completed training in accordance with regulations and waiver requirements. OLTL directly supervises QMET activities through the QMET statewide coordinator to ensure that providers fulfill training requirements in accordance with state and waiver requirements. If a provider has not met training requirements, the provider is required to submit a CAP. The provider has 15 business days to submit a completed CAP to the appropriate regional QMET, and OLTL reviews and approves the CAP within 30 business days of submission. The QMET verifies the CAP action steps are in place according to the timeframe as written in the CAP. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP. If the provider is unable or unwilling to develop a CAP which addresses and remediates each of the findings, OLTL takes action against the provider up to and including disenrollment. The provider has the right to appeal.	training, outlined in this waiver. The Quality Management Efficiency Teams (QMETs) are the monitoring agent for OLTL. The QMET monitoring tool and database outlines each qualification a provider must meet. The qualifications are categorized according to provider type. Provider type is defined as the service(s) the provider offers to waiver participants as outlined in the service definition. The QMET monitoring tool and database collects the information discovered by the QMETs during reviews for data analysis and aggregation purposes. Through this process, if a QMET discovers a provider does not meet one or more of the qualifications, the provider develops a Corrective Action Plan (CAP). The provider needs to demonstrate through the CAP that it can meet the regulations and waiver provider qualifications and develop a process on how to continue compliance in the future. The provider has 15 business days to submit a completed CAP to the appropriate regional QMET, and OLTL reviews and approves (or disapproves) the CAP within 30 business days of submission. The QMET verifies the approved CAP action steps are in place according to the timeframe as written the CAP. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP. If the provider is unable or unwilling to develop a CAP which addresses and remediates each of the findings, OLTL takes action against the provider up to and including disenrollment. The provider has the right to appeal. ~~Subassurance a.i.c- The QMET monitoring tool ascertains if the provider has completed training in accordance with regulations and waiver requirements. OLTL directly supervises QMET activities through the QMET statewide coordinator to ensure that providers fulfill training requirements in accordance with state and waiver requirements. If a provider has not met training requirements, the provider is required to submit a CAP. The provider has 15 business~~	

		~~days to submit a completed CAP to the appropriate regional QMET, and OLTL reviews and approves the CAP within 30 business days of submission. The QMET verifies the CAP action steps are in place according to the timeframe as written in the CAP. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP. If the CAP is insufficient, OLTL works with the provider to develop an appropriate CAP. If the provider is unable or unwilling to develop a CAP which addresses and remediates each of the findings, OLTL takes action against the provider up to and including disenrollment. The provider has the right to appeal.~~	
Appendix D Quality Improvement: Service Plan	SP-5: Number and percent of waiver providers who delivered services in the type, scope, amount, frequency, and duration specified in the Individual Service Plan (ISP). Numerator: Number of waiver providers who delivered services in the type, scope, amount, frequency, and duration specified In the Individual Service Plan Denominator: Total number of providers reviewed	SP-5: Number and percent of waiver providers who delivered services in the ~~type, scope,~~ amount, frequency, and duration specified in the Individual Service Plan (ISP). Numerator: Number of waiver providers who delivered services in the ~~type, scope,~~ amount, frequency, and duration specified In the Individual Service Plan Denominator: Total number of providers reviewed	Performance measure SP-5 is divided into 3 separate PMs: SP-5 (amount, frequency, and duration), SP-9 (type) and SP-10 (scope)
Appendix D Quality Improvement: Service Plan		**SP-9: Number and percent of waiver providers who delivered services in the type specified in the Individual Service Plan (ISP).** **Numerator: Number of waiver providers who delivered services in the type specified In the Individual Service Plan** **Denominator: Total number of providers reviewed**	Performance measure SP-5 is divided into 3 separate PMs: SP-5 (amount, frequency, and duration), SP-9 (type) and SP-10 (scope)
Appendix D Quality Improvement: Service Plan		**SP-10: Number and percent of waiver providers who delivered services in the scope specified in the Individual Service Plan (ISP).** **Numerator: Number of waiver providers who delivered services in the scope specified In the Individual Service Plan** **Denominator: Total number of providers reviewed**	Performance measure SP-5 is divided into 3 separate PMs: SP-5 (amount, frequency, and duration), SP-9 (type) and SP-10 (scope)
Appendix D(a)(ii) Quality Improvement: Service Plan	BFFSP staff reviews 100% of new ISPs and 100% of ISPs that have a 10% change in services using the guidelines specified in the OLTL Service Plan Review Protocol. This ongoing review is collected in the Service Plan Review Database where the data is aggregated monthly and quarterly for tracking and trending by	At the Service Coordination Agency, the SC supervisor reviews the ISP for completeness and appropriateness prior to submitting the ISP to the Bureau of ~~Individual Support (BIS)~~ **Fee For Service Programs (BFFSP)** for approval. The supervisor is the first step in the monitoring process.	Revised language regarding the methods OLTL uses to assess the quality of service plans and service planning. The previous language was outdated.

	the Service Plan (SP) Assurance Liaison in the BQAPA. The SP Assurance Liaison tracks the sample size to ensure a statistically valid sample using CMS sampling parameters has been reviewed. The SP Assurance Liaison also performs a quarterly retrospective review of the ISPs reviewed by BFFSP in the previous three months using the same review criteria. Data is pulled from the OLTL Complaint Database regarding complaints received about service plans. The SP Assurance Liaison monitors a 100% sample of the service plan complaints on a monthly basis to track and trend service plan issues for potential system improvement. The SP Assurance Liaison reviews data from the OLTL participant satisfaction surveys for questions # 12 and 13 for both New and Annual surveys, pertaining to participant's needs and goals, and delivery of services. 100% of returned surveys responses are monitored and aggregated three times per year. Quarterly, the OLTL conducts a representative sample review of participants authorized services and claims to determine if participants are receiving services in the type, amount and frequency specified in the ISP. See Appendix H for more information on BQAPA.	**OLTL uses eight performance measures for the Service Plan assurance. Data sources for these measures include the Retrospective Service Plan Review Report, the Participant Review Tool (PRT), EIM, and onsite provider review by the QMET. The outcome of each review is captured in the Retrospective Service Plan Report. QMET monitoring and retrospective service plan reviews are conducted using random samples sufficient to estimate accuracy with a 95% confidence level and a 5% margin of error. The sample size for each calendar year is determined by using the Raosoft® Sample Size Calculator, the waiver population size, and the 5% error/95% confidence/50% distribution levels to identify a representative sample.** **Five of the performance measures are derived from the retrospective service plan review process and are reported on the above-mentioned Retrospective Service Plan Report. OLTL collects a statistically valid sample of service plans and reviews them to verify the following:** • **that the ISP is adequate and appropriate to the participant's needs, capabilities, and desired outcomes, as indicated by the assessment,** • **that the ISP addresses all of a participant's personal goals (through waiver or non-waiver services),** • **that the ISP was reviewed and revised prior to the waiver participant's annual review date,** • **whether or not participants are receiving services in the type, scope, amount, frequency, and duration specified in the ISP, and** • **that waiver participants are receiving opportunities to choose services and providers** **The PRT, a standardized participant review tool conducted annually by the participant's SC, gathers information from participants on**	

		unmet service needs and has a specific question which addresses the participant's receipt of waiver services. Using reports pulled from Participant Supports records, OLTL monitors complaints regarding non-receipt of services. Lastly, the QMET teams conduct onsite provider reviews to determine the number and percent of waiver providers who delivered services in the type, scope, amount, frequency and duration specified in the ISP. ~~BFFSP staff reviews 100% of new ISPs and 100% of ISPs that have a 10% change in services using the guidelines specified in the OLTL Service Plan Review Protocol. This ongoing review is collected in the Service Plan Review Database where the data is aggregated monthly and quarterly for tracking and trending by the Service Plan (SP) Assurance Liaison in the BQAPA. The SP Assurance Liaison tracks the sample size to ensure a statistically valid sample using CMS sampling parameters has been reviewed. The SP Assurance Liaison also performs a quarterly retrospective review of the ISPs reviewed by BFFSP in the previous three months using the same review criteria. Data is pulled from the OLTL Complaint Database regarding complaints received about service plans. The SP Assurance Liaison monitors a 100% sample of the service plan complaints on a monthly basis to track and trend service plan issues for potential system improvement. The SP Assurance Liaison reviews data from the OLTL participant satisfaction surveys for questions # 12 and 13 for both New and Annual surveys, pertaining to participant's needs and goals, and delivery of services. 100% of returned surveys responses are monitored and aggregated three times per year. Quarterly, the OLTL conducts a representative sample review of participants authorized services and claims to determine if participants are receiving services in the type, amount and frequency specified in the ISP. See Appendix H for more information on BQAPA.~~	

Appendix D(b)(i) Quality Improvement: Service Plan	The following language was added based on additional CMS RAI questions: As a part of OLTL's process during plan reviews, the plan reviewers review the plan for risk factors, identified needs, and personal choice reflected in the service plan. Plan reviewers review services requested for their relevance and sufficiency in meeting participant needs and risk factors, as well as the intended outcomes desired by the participant...	~~The following language was added based on additional CMS RAI questions:~~ As a part of OLTL's process during plan reviews, the plan reviewers review the plan for risk factors, identified needs, and personal choice reflected in the service plan. Plan reviewers review services requested for their relevance and sufficiency in meeting participant needs and risk factors, as well as the intended outcomes desired by the participant…	Removed outdated language.
Appendix G(a)(i) Quality Improvement: Health and Welfare	HW-1 Number and percent of unexplained or suspicious deaths for which review/investigation occurred Numerator: Unexplained or suspicious deaths for which review/investigation resulted in findings where appropriate follow-up or steps were taken Denominator: Total number of unexplained deaths	HW-1 Number and percent of unexplained or suspicious deaths for which review/investigation occurred Numerator: Unexplained ~~or suspicious~~ deaths for which review/investigation resulted in findings where appropriate follow-up or steps were taken Denominator: Total number of unexplained deaths	
Appendix G(a)(ii) Quality Improvement: Health and Welfare	Statistical reports on 100% of reported critical incidents and complaints are generated from the state's Enterprise Incident Management (EIM) system and these reports are reviewed monthly by the BQAPA HW Assurance Liaison for patterns in the types of incidents and complaints received. The Liaison is also looking for patterns and issues regarding how the incidents and complaints are processed, i.e. was the reporting timeframe met, etc., according to the elements of the performance measures. The HW Assurance Liaison reviews data from the OLTL participant satisfaction surveys for question # 16 pertaining to participants who indicate knowledge of how to report abuse, neglect and exploitation. One hundred percent of returned surveys responses are monitored and aggregated three times a year.	**Administrators and employees of LTSS providers, SCs, and individual providers of waiver services, are responsible for reporting critical incidents within 48 hours of their discovery through the Enterprise Incident Management system (EIM), an electronic data system that collects information regarding critical incidents involving waiver participants. Direct service providers are also required to notify the participant's SC within 24 hours of knowledge of the critical incident. Critical incidents that must be reported are defined in 55 Pa. Code § 52.3 and Appendix G of the CHC 1915(c) Waiver.** **All SCs and direct service providers are mandatory reporters under both the Adult Protective Services (APS) and the Older Adult Protective Services (OAPS) Acts. OLTL provides mandatory training to all SCs and direct service providers in their responsibilities as mandatory reporters. SCs and direct service providers are required to provide standard annual training for staff members providing services which contains items related to critical incidents and ensure compliance with the reporting requirements established in the APS and OAPS Acts. For both APS and OAPS, the provider must**	Revised language regarding the methods OLTL uses to monitor critical incidents. The previous language was outdated.

		immediately contact the appropriate law enforcement official to file a report when incidents involve sexual abuse, serious injury, serious bodily injury or suspicious death. These additional reporting requirements do not supplant a provider's reporting responsibilities through EIM. DHS and the Pennsylvania Department of Aging (PDA) are the state agencies responsible for receiving and investigating all reports of abuse, neglect or exploitation under APS and OAPSA. SCs are required to cooperate with APS and OAPS staff conducting the investigation, and the coordination of any services provided by the SCE. After completing their investigations, APS and OAPS staff provide essential information to the SCs to make necessary changes to the participant's PCSP to ensure the participant's health and welfare. **SCs are required to investigate, conclude, and report the outcomes of incident report investigations in EIM within thirty (30) calendar days of discovery of the incident unless the incident requires an extension to obtain additional information such as medical records, necessary input from providers, or for APS and OAPS investigations. As noted above, the SCs are not responsible for investigating incidents involving suspected cases of abuse, neglect, exploitation, or abandonment.** **OLTL's BCIS Critical Incident Management Unit (CIMU), the team that reviews OBRA critical incidents, is comprised of one social worker and one registered nurse. The team reviews critical incident reports generated in EIM to track and trend critical incidents, identifies patterns and concerns regarding how the incidents are processed, investigated, and remediated, ensures the implementation of risk mitigation measures, and works with SCs to assure that participant health and welfare is protected prior to closing the report. Participants who demonstrate a higher need for case management are referred to OLTL's Case Management Unit for appropriate follow-up.**	

		Please see Appendix H for more information regarding the ~~Assurance~~ **Quality Management** Liaison's role in the Quality Improvement Strategy. ~~Statistical reports on 100% of reported critical incidents and complaints are generated from the state's Enterprise Incident Management (EIM) system and these reports are reviewed monthly by the BQAPA HW Assurance Liaison for patterns in the types of incidents and complaints received. The Liaison is also looking for patterns and issues regarding how the incidents and complaints are processed, i.e. was the reporting timeframe met, etc., according to the elements of the performance measures.~~ ~~The HW Assurance Liaison reviews data from the OLTL participant satisfaction surveys for question # 16 pertaining to participants who indicate knowledge of how to report abuse, neglect and exploitation. One hundred percent of returned surveys responses are monitored and aggregated three times a year.~~	
Appendix G(b)(i) Quality Improvement: Health and Welfare	Individual incidents of a severe nature are investigated and reviewed in accordance with Appendix G. When it is discovered that a participant has more than three reportable incidents within the past 365 days, the Health & Welfare (HW) Liaison reviews and analyzes the incidents to determine the effect on the participant. If the pattern of incidents has an effect on the health and welfare of the participant, the HW Liaison issues a QIP (see Appendix H) for immediate intervention. The QIP, with the BFFSP recommendations or action plan, is returned to the BQAPA within 15 business days. The BQAPA reviews and approves the QIP, notifying BFFSP of approval and initiating the follow-up process (QIP Protocol). The BQAPA reviews for patterns involving providers, geographic areas, etc. If specific provider(s) are involved in a pattern of frequent incidents, a referral is made to the Quality	~~Individual~~ **All critical** incidents ~~of a severe nature~~ are investigated and reviewed in accordance with Appendix G. When it is discovered that a participant has more than three reportable incidents within the past 365 days, the ~~Health & Welfare (HW) Liaison reviews and analyzes the incidents~~ **Service Coordinator is required to complete a trend analysis** to determine the effect on the participant. If the pattern of incidents has an effect on the health and welfare of the participant, the Service Coordinator must ensure preventative corrective action. ~~the HW Liaison issues a QIP (see Appendix H) for immediate intervention. The QIP, with the BFFSP recommendations or action plan, is returned to the BQAPA within 15 business days. The BQAPA reviews and approves the QIP, notifying BFFSP of approval and initiating the follow-up process (QIP Protocol).~~ **All incidents involving Abuse, Neglect, or Exploitation are referred to and investigated by the protective services agency. The Service**	Revised language regarding the methods OLTL uses to monitor critical incidents. The previous language was outdated.

	Management Efficiency Team (QMET) for a targeted review and possible Corrective Action Plan (CAP). The BQAPA also refers these participants to BFFSP through the Quality Improvement Plan process (QIP) under the standard of ensuring health and welfare. Individual incidents of a severe nature are investigated and reviewed in accordance with Appendix G. If the BQAPA discovers that a complaint was not acted upon in accordance with waiver standards, the BQAPA issues a Statement of Finding and requests a QIP from the BFFSP.	**Coordinator works with the protective services worker to ensure risk mitigation.** ~~The BQAPA reviews for patterns involving providers, geographic areas, etc.~~ **The Critical Incident Management Unit monitors provider compliance with Incident Management requirements.** If specific provider(s) are involved in a pattern of frequent incidents, a referral is made to the Quality Management Efficiency Team (QMET) for a targeted review and possible Corrective Action Plan (CAP). The **Incident Management Team** ~~BQAPA~~ also refers these participants to BFFSP through the Quality Improvement Plan process (QIP) under the standard of ensuring health and welfare. ~~Individual incidents of a severe nature are investigated and reviewed in accordance with Appendix G.~~ If the **Incident Management Team** ~~BQAPA~~ discovers that a complaint was not acted upon in accordance with waiver standards, the **Incident Management Team** ~~BQAPA~~ issues a Statement of Finding and requests a QIP from the BFFSP.	
Appendix I(a)(ii) Quality Improvement: Financial Accountability	A "Paid Claims Report" has been developed that runs every paid claim against a valid list of procedure codes. 100% of all paid claims are run through the query which is written to list any claims that paid with an incorrect code. If any claims would pay and not be valid, the circumstances of each claim would be investigated FA-1: The QMU Liaison reviews the report that has been run. If no claims are listed on the report, all of the paid claims paid using correct procedure codes that are valid under the waiver. FA-2: The QMU Liaison reviews the data that has been reported by the QMET teams. The data is tracked and trended against prior reporting periods to draw conclusions relating to levels of compliance. FA-3: The QMU Liaison reviews the report that has been run. Any claims that do not pay at the correct rate will not meet the	**The Department of Human Services' PROMISe™ claims processing system includes multiple claims processing edits and audits to ensure process and payment validity. PROMISe™ is the Department's CMS certified MMIS and is administered by the Department's Office of Medical Assistance Programs (OMAP) and the Department's Bureau of Information Systems (BIS). OBRA Waiver payment rates were set by an outside vendor based on a CMS approved rate setting methodology. Once the rates have been finalized and approved, they are then loaded into the PROMISe™ claims processing system by DHS's Bureau of Data and Claims Management. These rates go through a testing process to ensure correctness before they are loaded in the live claims environment.** **The PROMISe™ system contains numerous edits and audits to ensure that claims are paid timely and appropriately. In order to be**	Revised language regarding the methods the Department and OLTL use to monitor claims processing. The previous language was outdated.

	Assurance. These claims would be reprocessed at the correct rate. FA-4: The QMU Liaison reviews the report that has been run. Any claims that do not pay timely will not meet the Assurance. Only timely claims should be paid. FA-5: The QMU Liaison reviews the report that has been run. The rate file is delivered to OLTL electronically. OLTL reviews the file for errors. DHS Bureau of Data and Claims Management does testing after rates are loaded into PROMISe to ensure the rates are loaded correctly. The rates are reviewed each time any changes are made to the PROMISe rate tables. Universe. FA-1: Numerator: Total number of claims that paid using correct procedure codes. SFY 2013-14 – 881,396 claims. Denominator: Total number of paid claims. SFY 2013-14 – 881,396 claims. FA-2. 766 total providers. Numerator: number of providers reviewed that paid correctly. Denominator: number of providers reviewed during each quarter. FA-4. 140 payment rates. FA-1: Paid Claims Report is analyzed. Based on results, further investigation of the paid claims and processing system may be needed. FA-2: Based on the results from QMET on site findings, providers will make necessary changes through the Corrective Action Plan remediation process. OLTL is exploring the option of collection this data systemically instead of onsite reviews. FA-5: Rates will not become official without passing the PA review process that they were done using the correct methodology. If a claim passed all of the edit and audit checks in the PA PROMISe claims processing system, they have been coded and paid for in accordance with the reimbursement methodology. QMET completes a TSADF claims review of waiver providers as part of the regulatory monitoring which includes initial and	**paid for submitted claims, providers must be enrolled as Medical Assistance providers and entered as such into PROMISe™. PROMISe™ verifies participant information in the Client Information System (CIS), which contains MA participant's eligibility information, 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, OLTL's case management system, that the provider(s) and service(s) on the claim are included in the participant's approved waiver service plan.** **Claims that are incomplete or contain invalid information are denied, ensuring compliance with what is specified in the approved waiver. If a systemic problem occurs, OLTL is notified through calls received on the Provider Helpline. Lastly, post-payment reviews are conducted by the QMET teams to verify that services were delivered and were billed correctly by providers. If OLTL identifies any billing errors through the audit process, these claims are submitted and processed for recoupment from the provider.** **In addition to onsite reviews, OLTL uses a number of reports from PROMISe™, including a Paid Claims Report and Rate Setting and Payment Report to evaluate the remaining four performance measures.** ~~A "Paid Claims Report" has been developed that runs every paid claim against a valid list of procedure codes. 100% of all paid claims are run through the query which is written to list any claims that paid with an incorrect code. If any claims would pay and not be valid, the circumstances of each claim would be investigated~~ ~~FA-1: The QMU Liaison reviews the report that has been run. If no claims are listed on the report, all of the paid claims paid using correct procedure codes that are valid under the waiver.~~ ~~FA-2: The QMU Liaison reviews the data that has been reported by the QMET teams. The data is tracked and trended against prior~~	

	follow-up monitoring. Comprehensive on-site monitoring of HCBS providers are conducted every two (2) years. Additional time frames for more frequent monitoring are determined by the existence of an active corrective action plan (CAP), provider history (complaints, incident reports, etc.), provider type and as identified by the OLTL. Claims are reviewed by QMET to verify that billing is supported in the correct type, scope, amount, duration and frequency (TSADF) as written in the individual service plan (ISP). In the agency model of service, the ISP is broken down by service for the Direct Service Providers (DSP) on a Service Authorization Form (SAF). The SAF lists all of the necessary information required to perform the services being ordered and based on the provider type ie: personal assistance service, RN Services, etc. At a DSP review, QMET requests all SAFs and timesheets for a statistically significant sample of billing. The information requested is for a one year period ending with the month prior to the month of the review. The SAFs and timesheets are compared to confirm that the services ordered were the services provided. Any deviations between the timesheets and SAFs that are not documented will result in a finding and the provider will be cited. Other issues that could result in a provider being cited are: the provider does not maintain documentation in the record of the SAF, the timesheet is not clear and TSADF cannot be determined, timesheets are missing etc. Pennsylvania contracted with a vendor to assist with setting the payment rates. Parameters were agreed upon that would be critical to achieving the rate setting methodology. The rates went through a comment and vetting process. These accepted approved rates are loaded into the PA PROMISe payment processing system, that the claims pay against, only after CMS approval of OLTL's rate methodology. An outside vendor under	~~reporting periods to draw conclusions relating to levels of compliance.~~ ~~FA-3: The QMU Liaison reviews the report that has been run. Any claims that do not pay at the correct rate will not meet the Assurance. These claims would be reprocessed at the correct rate.~~ ~~FA-4: The QMU Liaison reviews the report that has been run. Any claims that do not pay timely will not meet the Assurance. Only timely claims should be paid.~~ ~~FA-5: The QMU Liaison reviews the report that has been run. The rate file is delivered to OLTL electronically. OLTL reviews the file for errors. DHS Bureau of Data and Claims Management does testing after rates are loaded into PROMISe to ensure the rates are loaded correctly. The rates are reviewed each time any changes are made to the PROMISe rate tables.~~ ~~Universe. FA-1: Numerator: Total number of claims that paid using correct procedure codes. SFY 2013-14 – 881,396 claims. Denominator: Total number of paid claims. SFY 2013-14 – 881,396 claims.~~ ~~FA-2. 766 total providers. Numerator: number of providers reviewed that paid correctly. Denominator: number of providers reviewed during each quarter.~~ ~~FA-4. 140 payment rates.~~ ~~FA-1: Paid Claims Report is analyzed. Based on results, further investigation of the paid claims and processing system may be needed.~~ ~~FA-2: Based on the results from QMET on site findings, providers will make necessary changes through the Corrective Action Plan remediation process. OLTL is exploring the option of collection this data systemically instead of onsite reviews.~~ ~~FA-5: Rates will not become official without passing the PA review process that they were done using the correct methodology.~~ ~~If a claim passed all of the edit and audit checks in the PA PROMISe claims processing system, they have been coded and paid for in accordance with the reimbursement methodology.~~	

	the direction of the Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) Bureau of Data and Claims Management (BDCM) run the rates and claims in a test environment to be certain that they are working correctly before they are loaded into the live PROMISe environment for claims processing. The Quality Management Efficiency Teams (QMETs) are the State Medicaid Agency's (OLTL) regional provider monitoring agents. They conduct monitoring reviews every 2 years with every provider of waiver services. Using a standard monitoring tool which incorporates the Financial Accountability requirements as listed in the waiver, the QMET verifies each requirement during the review. The QMET review includes verifying claims submitted in PROMISe with service plans. A random sample of provider, employee, and consumer financial records are reviewed to ensure compliance with waiver standards. Claims data is examined against a sample of HCSIS files to determine if paying properly based on plan authorizations The State uses the following website to determine sample sizes: http://www.raosoft.com/samplesize.html	~~QMET completes a TSADF claims review of waiver providers as part of the regulatory monitoring which includes initial and follow-up monitoring. Comprehensive on-site monitoring of HCBS providers are conducted every two (2) years. Additional time frames for more frequent monitoring are determined by the existence of an active corrective action plan (CAP), provider history (complaints, incident reports, etc.), provider type and as identified by the OLTL.~~ ~~Claims are reviewed by QMET to verify that billing is supported in the correct type, scope, amount, duration and frequency (TSADF) as written in the individual service plan (ISP). In the agency model of service, the ISP is broken down by service for the Direct Service Providers (DSP) on a Service Authorization Form (SAF). The SAF lists all of the necessary information required to perform the services being ordered and based on the provider type ie: personal assistance service, RN Services, etc.~~ ~~At a DSP review, QMET requests all SAFs and timesheets for a statistically significant sample of billing. The information requested is for a one year period ending with the month prior to the month of the review. The SAFs and timesheets are compared to confirm that the services ordered were the services provided. Any deviations between the timesheets and SAFs that are not documented will result in a finding and the provider will be cited. Other issues that could result in a provider being cited are: the provider does not maintain documentation in the record of the SAF, the timesheet is not clear and TSADF cannot be determined, timesheets are missing etc.~~ ~~Pennsylvania contracted with a vendor to assist with setting the payment rates. Parameters were agreed upon that would be critical to achieving the rate setting methodology. The rates went through a comment and vetting process. These accepted approved rates are loaded into the PA PROMISe payment processing system, that the claims pay against, only after CMS approval of OLTL's rate methodology. An outside vendor under the direction of the Department of Human Services (DHS) Office of Medical Assistance~~	

		~~Programs (OMAP) Bureau of Data and Claims Management (BDCM) run the rates and claims in a test environment to be certain that they are working correctly before they are loaded into the live PROMISe environment for claims processing.~~ ~~The Quality Management Efficiency Teams (QMETs) are the State Medicaid Agency's (OLTL) regional provider monitoring agents. They conduct monitoring reviews every 2 years with every provider of waiver services. Using a standard monitoring tool which incorporates the Financial Accountability requirements as listed in the waiver, the QMET verifies each requirement during the review. The QMET review includes verifying claims submitted in PROMISe with service plans. A random sample of provider, employee, and consumer financial records are reviewed to ensure compliance with waiver standards. Claims data is examined against a sample of HCSIS files to determine if paying properly based on plan authorizations~~ ~~The State uses the following website to determine sample sizes: http://www.raosoft.com/samplesize.html~~	
Appendix I(b)(i) Quality Improvement: Financial Accountability	If a report reveals a claim that is overpaid in accordance with the rate methodology, OLTL/Bureau of Quality & Provider Management initiates steps to recoup the overpayment. The following language was added based on CMS RAI questions: If the provider and OLTL cannot come to a mutual agreement regarding the recoupment of an overpayment, the provider may request an appeal in writing with the DHS Bureau of Hearing and Appeals (BHA). After hearing testimony from both OLTL and the provider, the Hearing Officer would make the final decision regarding the recoupment. Noncompliance discovered during QMET monitoring is remediated through Corrective Action Plans (CAPs), requiring providers to submit their action steps to remedy their non-compliance. The following language was added based on CMS RAI questions concerning QMET statistical sampling tool: • A Cognos report is created from the HCBS claims data that is	~~If a report reveals a claim that is overpaid in accordance with the rate methodology, OLTL/Bureau of Quality & Provider Management initiates steps to recoup the overpayment. The following language was added based on CMS RAI questions: If the provider and OLTL cannot come to a mutual agreement regarding the recoupment of an overpayment, the provider may request an appeal in writing with the DHS Bureau of Hearing and Appeals (BHA). After hearing testimony from both OLTL and the provider, the Hearing Officer would make the final decision regarding the recoupment.~~ ~~Noncompliance discovered during QMET monitoring is remediated through Corrective Action Plans (CAPs), requiring providers to submit their action steps to remedy their non-compliance.~~ ~~The following language was added based on CMS RAI questions concerning QMET statistical sampling tool:~~ ~~• A Cognos report is created from the HCBS claims data that is stored in the Commonwealth of PA Enterprise Data Warehouse.~~ ~~• The Cognos report's data is manually verified.~~	Revised language regarding the methods the Department and OLTL use to monitor claims processing. The previous language was outdated.

	stored in the Commonwealth of PA Enterprise Data Warehouse. • The Cognos report's data is manually verified. • The size of the data sample is supported through the use of a sample size calculator available at https://content.metrixmatrix.com/sample.html. • The report's data is randomly sorted through Microsoft Excel Macros. • The random data sample that is created by the Microsoft Excel Macros is used to identify the HCBS claims that are to be reviewed for a HCBS provider. Rate Setting Methodology is examined and analyzed on a yearly basis and adjusted if inconsistent with the waiver.	~~• The size of the data sample is supported through the use of a sample size calculator available at https://content.metrixmatrix.com/sample.html.~~ ~~• The report's data is randomly sorted through Microsoft Excel Macros.~~ ~~• The random data sample that is created by the Microsoft Excel Macros is used to identify the HCBS claims that are to be reviewed for a HCBS provider.~~ ~~Rate Setting Methodology is examined and analyzed on a yearly basis and adjusted if inconsistent with the waiver.~~	
Appendix C Service Definitions	…teleservices may be provided in accordance with the requirements in the Additional Needed Information Section of the Main Module.	… teleservices may be provided in accordance with the requirements in ~~the Additional Needed Information Section of the Main Module~~ **Appendix C-1-d**.	This sentence was amended in the following service definitions: Cognitive Rehabilitation Therapy, Counseling, and Nutritional Consultation. Teleservices information was moved from the Main Module to Appendix C-1-d.
Appendix C Service Definitions Behavior Therapy Services	N/A	**Behavior Therapy teleservices may be provided in accordance with the requirements in Appendix C-1-d. Behavior Therapy may be provided via teleservice 100% of the time as reflected by the assessed need and participant choice. The provider is responsible for providing in-person training to the participant and/or the participant's representative, if needed. The participant may choose to have the in-person training at the provider's office or at participant's private home/community setting. Service coordinators must discuss the use of remote monitoring with the participant and/or the participant's representative and document the participant's agreement in the PSCP prior to initiating the teleservice delivery method. The service coordinator and the participant must develop a back-up plan in the event of equipment/technology failure. If this were to happen, the**	Adding Teleservice as a delivery mode for Behavior Therapy.

		participant may choose to have the service in-person at the provider's office or in the private home/community setting. The participant will have control over the equipment and may turn the equipment on and off if they choose to do so. The provider must inform and train the participant of this option and document it in the treatment plan.	
Appendix C Service Definitions Benefits Counseling	N/A	**Benefits Counseling teleservices may be provided in accordance with the requirements in Appendix C-1-d. Benefits Counseling may be provided via teleservice 100% of the time as reflected by the assessed need and participant choice. The provider is responsible for providing in-person training to the participant and/or the participant's representative, if needed. The participant may choose to have the in-person training at the provider's office or at participant's private home/community setting. Service coordinators must discuss the use of remote monitoring with the participant and/or the participant's representative and document the participant's agreement in the PSCP prior to initiating the teleservice delivery method. The service coordinator and the participant must develop a back-up plan in the event of equipment/technology failure. If this were to happen, the participant may choose to have the service in-person at the provider's office or in the private home/community setting. The participant will have control over the equipment and may turn the equipment on and off if they choose to do so. The provider must inform and train the participant of this option and document it in the treatment plan.**	Adding Teleservice as a delivery mode for Benefits Counseling.