



MENTAL RETARDATION BULLETIN

COMMONWEALTH OF PENNSYLVANIA · DEPARTMENT OF PUBLIC WELFARE

DATE OF ISSUE

June 8, 2001

EFFECTIVE DATE

July 1, 2001

NUMBER

00-01-02

SUBJECT:

Approved Consolidated Waiver

BY:

Nancy R. Thaler
Deputy Secretary for Mental Retardation

SCOPE:

County Mental Health/Mental Retardation Administrators

PURPOSE:

The purpose of this bulletin is to transmit the Department's approved Consolidated Waiver application, effective July 1, 2000.

BACKGROUND:

After the first three years of service operation, home and community based waiver services provided under Section 1915 © of the Social Security Act are approved by the Health Care Financing Administration (HCFA) for five-year renewal periods. Waiver renewals are based on satisfactory provision of waiver services, meeting state assurances, and a written application, which describes how services will be provided during the renewal period.

INFORMATION:

HCFA approved the Pennsylvania Department of Public Welfare's application for a five-year renewal of its 2176 Consolidated Waiver for individuals with mental retardation. The renewal period, based on HCFA's attached letter to Secretary Feather O. Houston, is from July 1, 2000 to June 30, 2005. The attached waiver application establishes the framework for the provision of waiver services during the renewal period.

The following modifications are incorporated within this waiver renewal.

- The name of the service formally known as "physical adaptations" is now called "environmental accessibility adaptations". The maximum state and federal participation limit for environmental accessibility adaptations is \$20,000 per recipient household. Stair gliders and elevator systems are eligible services under this service area.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Appropriate Regional Program Manager

- Service management will be removed from the waiver as a service effective July 1, 2001. Service management will be provided under Targeted Service Management (TSM) as of July 1, 2001.
- Service liability, known as post-eligibility treatment of income, was removed from the Consolidated Waiver, effective July 1, 2000. This step makes all 1915 (c) waivers administered by the Office of Mental retardation free from liability charges to individuals determined financially eligible by the County Assistance Office.

County MH/MR Programs can purchase certain administrative services in accordance with the MH/MR Act of 1966 and applicable provisions of the Pennsylvania County Code. Page 10A of the waiver application specifies those administrative functions that shall be retained by the County. When administrative services are purchased by the County, the County MH/MR Program shall continue to retain ultimate responsibility for compliance with its agreement with the Department for the administration of waiver funded services.

The Department has been notified that the use of co-signed checks is not an approved payment method under the waiver. County MH/MR Programs are authorized to follow supplemental grant agreement provisions related to self-determination funding options until this area is incorporated into a new supplemental grant agreement which is expected by July 1, 2001.

Specific County MH/MR Program responsibilities are stipulated in the supplemental grant agreement between County MH/MR Programs and the Department. The County's current supplemental grant agreement (MR Bulletin, 00-96-08, issued July 1, 1996) will continue to be in effect until superceded by a new grant agreement.

Any future amendments to this waiver application will be distributed under the Mental Retardation Bulletin format, once the amendment receives HCFA approval. County Mental Health/Mental Retardation Programs will be responsible for instituting changes necessitated by such amendments based on instructions provided by the Department.

All County Mental Health/Mental Retardation Programs participating in the waiver are expected to retain a copy of the approved waiver application, and any future amendments for the duration of the five-year renewal period.

Suite 216, The Public Ledger Bldg
150 S. Independence Mall West
Philadelphia, PA 19106-3413

JAN 29 2001

Feather O. Houstoun
Secretary
Department of Public Welfare
Room 333, Health & Welfare Building
7th & Forster Streets
P.O. Box 2675
Harrisburg, Pa 17120-2675

Re: Pennsylvania's Home and Community-Based Services Waiver for Individuals with
Mental Retardation (HCFA Control # 0147.90.R2)

Dear Ms. Houstoun:

I am pleased to inform you that your request dated May 12, 2000, as supplemented by the additional information dated December 20, 2000, to renew your Home and Community-Based Services Waiver for Individuals with Mental Retardation has been approved. The waiver, authorized under the provisions of § 1915(c) of the Social Security Act, will enable the Commonwealth to provide home and community-based services to individuals aged 3 and over who are mentally retarded. Specifically, the Waiver for Individuals with Mental Retardation will enable you to provide case management; respite care; habilitation, including residential habilitation, day habilitation, prevocational services, educational services, and supported employment services; environmental accessibility adaptations; transportation; chore services; private duty nursing; specialized therapies; and permanency planning for children and youth. Individuals served in the waiver would otherwise require institutional care in an intermediate care facility for the mentally retarded or persons with related conditions. This waiver now will carry HCFA control number 0147.90.R2. Please refer to this number in all future correspondence regarding this waiver renewal.

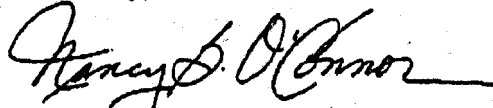
Nancy R. Thaler, Deputy Secretary for the Office of Mental Retardation, has assured HCFA that on or before June 30, 2001, Pennsylvania will provide case management services to waiver consumers under the Targeted Case Management option of the State plan. This option was chosen by the Commonwealth to meet the *Free choice of providers* requirement applicable to case management service now provided as a waiver service. In a related matter, Mel Knowlton, Chief, Division of Policy Development and Program Support of the Office of Mental Retardation has agreed to make changes to the contracts between the counties and waiver providers so that they are consistent with HCFA policy. We are currently developing policies on a number of issues that have surfaced as a result of our review of the contracts. We expect to advise the Office of Mental Retardation of the applicable policies in the near future.

Based on the assurances and information you provided, I approve the waiver renewal request cited above for a 5-year period, effective July 1, 2000, the date you requested. This approval is subject to your agreement to provide home and community-based services, on an annual basis, to no more individuals than those indicated as the value of "C" in your approved cost and utilization estimates (shown below). In these estimates, "C" represents the unduplicated number of individuals served under the waiver during each waiver year. "D" represents the estimated average per capita costs of waiver services during each waiver year.

| Waiver Year | "C" Value | "D" Value |
|-------------------------------------|-----------|-----------|
| Year 1 July 1, 2000 - June 30, 2001 | 14,587 | \$ 48,931 |
| Year 2 July 1, 2001 - June 30, 2002 | 15,493 | \$ 52,419 |
| Year 3 July 1, 2002 - June 30, 2003 | 16,491 | \$ 52,143 |
| Year 4 July 1, 2003 - June 30, 2004 | 17,387 | \$ 52,368 |
| Year 5 July 1, 2004 - June 30, 2005 | 18,279 | \$ 52,397 |

Please contact Bill Davis of the Philadelphia Regional Office at (215) 861-4204 if you have any questions.

Sincerely,



Nancy B. O'Connor
Acting Regional Administrator

SECTION 1915 (c) WAIVER FORMAT

1. The State of Pennsylvania requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

- a. Yes b. No

If yes, the State assures that no more than 200 individuals will be served on this waiver at any one time.

This waiver is requested for a period of (check one):

- a. 3 years (Initial waiver)
b. 5 years (Renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

- a. Nursing facility (NF)
b. ICF/MR
c. Hospital
d. NF (served in hospital)
e. ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) if individuals who would be otherwise eligible for waiver services:

- a. aged (age 65 and older)
b. disabled
c. aged and disabled

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6. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to waiver recipients.
7. The State requests that the following home and community-based services, as described and defined in appendix B.1 of this request, be included under this waiver:
 - a. _____ Case management
 - b. _____ Homemaker
 - c. _____ Home health aide services
 - d. _____ Personal care services
 - e. X Respite care
 - f. _____ Adult day health
 - g. X Habilitation
 - X Residential habilitation
 - X Day habilitation
 - X Prevocational services
 - X Supported employment services
 - X Educational services
 - h. X Environmental accessibility adaptations
 - i. _____ Skilled nursing
 - j. X Transportation
 - k. _____ Specialized medical equipment and supplies
 - l. X Chore services
 - m. _____ Personal Emergency Response Systems
 - n. _____ Companion Services
 - o. X Private Duty Nursing

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- p. Family Training
- q. Attendant Care
- r. Adult Residential Care
- Adult Foster Care
- Assisted Living
- s. Extended State plan services:
Check all that apply:
 - Physician Services
 - Home health care services
 - Physical therapy services
 - Occupational therapy services
 - Speech, hearing and language services
 - Prescribed drugs
 - Other (specify):
- t. Other services (specify): specialized therapies;
permanency planning for children and youth

- 8. The State assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
- 9. Eligibility groups included under the waiver are reflected in Appendix C-1.

Waiver recipients meet the appropriate State plan requirements for the eligibility groups included under the waiver unless §1902(a)(10)(C)(i)(III) has been waived in order to use income and resource rules for the medically needy.

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12. Waiver services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.
13. Federal financial participation will not be available in expenditures for the cost of room and board, except when provided as part of respite care in a facility approved by the State that is not a private residence. Meals provided under any waiver service (or combination of services) will not constitute a "full nutritional regimen" (3 meals a day).
14. The State will refuse to offer home and community-based services to any recipient for whom it can reasonably be expected that the cost of home or community-based services furnished to that recipient would exceed the cost of a level of care referred to in item 2 of this request.
- a. X Yes ***(See Attachment, p. 6a)** b. No
15. The Medicaid agency provides the following assurances to HCFA:
- a. Necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those standards include:
1. adequate standards for all types of providers that provide services under the waiver (see Appendix B);
 2. assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
 3. assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

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14. (**Attachment**)

The Department will accept the option to exclude those individuals from the waiver for whom there is a reasonable expectation that home and community based services would be more expensive than the Medicaid services the individual would otherwise receive in an ICF/MR. This option shall be exercised by the County MH/MR Program based on the availability of state and federal funds. This exclusion shall not prohibit a County MH/MR Program from serving individuals under the waiver whose cost for home and community services is more than the cost of ICF/MR care as long as the average cost for all waiver recipients is maintained within the State's cost effectiveness limits. The Department will be responsible for maintaining necessary financial controls and structures in this area through its allocation and rebudget process.

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- b. The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.
- c. When a recipient is determined to be likely to require a level of care indicated in item 2 of this request, the recipient or his or her legal representative will be:
 - 1. informed of any feasible alternatives under the waiver; and
 - 2. given the choice of either institutional or home and community-based services.
- d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, Subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice or the provider(s) of their choice.
- e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditure for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
- f. The agency's actual total expenditure for home and community-based and other Medicaid services provided to individuals under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in the setting(s) indicated in item 2 of this request, in the absence of the waiver.
- g. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the recipients. The information will be consistent with a data collection plan designed by HCFA.

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- h. The agency will assure financial accountability for funds expended for home and community-based services, and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes

b. _____ No

- 17. The State assures that it will have in place a formal system by which it ensures the health and welfare of the recipients, through monitoring of the quality control procedures described in this waiver document. Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and the plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures the State will ensure the quality of services furnished under the waiver and the State plan to waiver recipients. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiency.
- 18. An effective date of July 1, 2000 is requested.
- 19. The State contact person for this request is Dana Olsen , who can be reached by telephone at (717) 783-5772.
- 20. This document, together with Appendices A through G, and all attachments, constitutes the State of Pennsylvania's request for home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

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The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: -----

Print Name: -----

Title: -----

Date: -----

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APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

Check one:

- The waiver will be operated directly by the Medical Assistance Unit of the Medicaid Agency.
- The waiver will be operated by _____, a separate agency of the State under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.
- The waiver will be operated by the State Office of Mental Retardation, a separate division within the single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver.

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Appendix A – Administration Attachment

All services and supports funded under this option are authorized by the County MH/MR Program pursuant to an agreement with the Department of Public Welfare, Office of Mental Retardation which establishes the County MH/MR Program's roles and responsibilities with regard to fiscal and program administration.

The County MH/MR Program can purchase fiscal and program administrative services in accordance with the MH/MR Act of 1966 and applicable provisions of the PA County Code. When administrative services are purchased by the county, the County MH/MR Program shall continue to retain ultimate responsibility for compliance with its agreement with the Department for the administration of waiver funded services. The County MH/MR Program shall also ensure that any purchased administrative services are established in writing pursuant to a contract or agreement. Regardless of how services are purchased, the County MH/MR Program is held responsible for adherence to all provisions of its agreement with the Department. Costs of purchased administrative services shall be paid through the Department's allocation for county administration of the waiver. Waiver service funding cannot be used for these purposes.

The following administrative functions shall be retained by the County MH/MR Program as a condition of federal and state funding participation under the waiver, and shall not be approved as functions that can be purchased outside of the County MH/MR Program.

1. Signing of the county's agreement with the Department for administration of waiver services.
2. Monitoring of assigned fiscal and program administrative services pursuant to a signed contract.
3. Determination of level of care eligibility for waiver applicants and recipients.
4. Provider enrollment and certification.
5. Submission of all waiver cost and utilization reports to the Department, including cost and utilization related to HCFA 372 submissions.
6. Authorization for waiver funded services, rates and charges.
7. Compliance with Single Audit Act.
8. Signing and monitoring of all provider contracts.
9. Control for allocated funds.

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APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1 DEFINITION OF SERVICES

1. **Services Management (Provided by Targeted Service Management (TSM) , effective July 1, 2001)**

Services Management, formerly identified as case management, is the single service that is responsible for intake, diagnosis, monitoring, needs assessment and evaluation along with location, coordination and monitoring of services for the individual.

Services are provided in accordance with County Mental Retardation Services Regulations (55 PA Code Chapter 6201) and policy, which is currently MR Bulletin #00-92-23 titled: County Responsibilities for Waiver Case Management.

Services assist individuals in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational and other services, regardless of funding source for the services to which access is gained. Service managers will also advocate for the rights of individuals in gaining access to appropriate home and community services.

The service manager is responsible for development, coordination and ongoing monitoring of the provision of services included in the individual's program plan. Additionally, the service manager can initiate and supervise the process of assessment and reassessment of individual level of care determinations and the review of individual program plans at such intervals as specified in Appendices C and D of this request.

Educational and professional qualifications of service managers are specified in Appendix B-2.

2. X **Respite Services**

Respite services consist of services which are provided on a short-term basis because of the absence or need for relief of those persons normally providing the care.

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Individuals can receive two categories of respite services: 24 hour overnight respite and temporary respite. 24 hour overnight respite is provided in segments of 24 hour units and includes overnight care. Temporary respite is respite services provided on less than a 24 hour overnight basis.

The County MH/MR Program shall ensure that each rate established for the provision of respite services includes all waiver eligible costs associated with that service, including the provider's cost for recruitment, transportation, supervision and training, where applicable.

Federal and State financial participation is being limited to:

1. Services provided for individuals residing in their own home or the home of relative, friend or other family. Respite services are not available for individuals who reside in agency operated community homes.
2. 30 days of 24 hour overnight respite per individual in a period of one year except when extended by a regional waiver pursuant to Family Resource Services Regulations, 55 PA Code Chapter 6350.16.
3. Temporary respite up to the number of hours stipulated in the individual's program plan.

FFP will not be claimed for the cost of room and board except when provided as part of respite services in a facility approved by the State that is not a private residence.

Respite services are provided in only the following location(s):

- Recipient's home or place of residence.
- Licensed or approved foster family home.
- Licensed community home or family living home.
- Licensed respite care community or family living home.
- Unlicensed home of a provider meeting qualifications in Appendix 2-B.
- Other community settings such as summer camp where the setting meets applicable state or local codes and the provider of service meets the provider qualifications established by the Department.

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Qualifications of providers of respite services are included in Appendix B-2. Applicable Keys amendment standards are included in Appendix B-3.

3. X **Community Habilitation**

Community Habilitation means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation may be provided up to 24 hours a day based on the needs of the individual receiving services. Included are provider training costs, supervisory costs, purchased personnel costs, and costs of necessary supplies, equipment and adaptive appliances. Services may be provided by a qualified family member or relative, independent contractor, or services agency.

In the case of providers who are family members, federal and state financial participation is excluded except when the following conditions are met:

- (1) The service provided is not a function which a relative would normally provide for the individual without charge as a matter of course in the usual relationship among members of the nuclear family.
- (2) The service would otherwise need to be provided by a qualified provider of habilitation services funded under the waiver.
- (3) The service is provided by a relative who meets the same qualifications that are currently established for other non-licensed providers of services by the Department.

This service consists of:

- (1) Habilitation provided in community homes and family living homes licensed by the Department under 55 Pa. Code Chapters 6400 and 6500. Services are limited to licensed settings established on or before January 1, 1996 with a licensed capacity of 10 or fewer individuals with mental retardation and to licensed settings established after January 1, 1996 with a licensed capacity of 4 or fewer individuals with mental retardation. ICF/MR settings with a licensed capacity of 10 or fewer residents which become established as a licensed community home through a waiver conversion process shall be eligible for waiver funding as long as the facility is ICF/MR certified for 10 beds or less on or prior to January 1, 1996.
- (2) Habilitation provided in other community settings approved or licensed by the State, including domiciliary care settings, foster family homes, community rehabilitation residences, and personal care homes. These settings must have a licensed and approved capacity of 10 or fewer individuals receiving care to receive habilitation funding in the residence.

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- (3) Habilitation provided in home and family settings which are not subject to Department licensing or approval when the provider of habilitation meets established requirements in Appendix B-2.
- (4) Habilitation provided in adult training facilities licensed under 55 Pa. Code Chapter 2380 and 6 Pa. Code, Chapter 11. Services consist of supervision, training, and support in general areas of self-care, communication, community participation, and socialization. Areas of emphasis include: therapeutic activities, fine and gross motor development, mobility, personal adjustment, use of community resources, and relationship development.
- (5) Prevocational services provided by facilities licensed under 55 Pa. Code Chapter 2390 when the services are not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or section 602 (16)

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and (17) of the Education of the Handicapped Act. Services consist of work experience and other developmental work training activities designed to promote movement into a higher level program. Activities include training designed to teach job-related skills, personal and work adjustment training designed to develop appropriate worker traits and teach an understanding of the work environment, and assessments of a beneficiary's vocational aptitude and potential.

Documentation is maintained in the file of each individual receiving this service to satisfy state assurances that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142 and Individuals with Disabilities Education Act (IDEA).

- (5) Supported employment services which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment is provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by the individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, or P.L. 94-142, as amended by IDEA. Documentation will be maintained in the file of each individual receiving these services to satisfy the state assurance that the service is not otherwise available under a program funded under the rehabilitation Act of 1973 or P.L. 94-142 and the Individuals with Disabilities Education Act (IDEA).

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational expenses such as the following:

- a. Incentive payments made to an employer of individuals receiving services to encourage or subsidize the employer's participation in a supported employment program;

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- b. Payments that are passed through to individuals receiving supported employment; or
- c. Payments for vocational training that is not directly related to an individual's supported employment program.

(6) Other habilitation services as defined below:

- Support that enables an individual to participate in community projects, associations, groups, and functions, such as support that assists an individual to participate in a volunteer association or a community work project.

- Support that enables an individual to participate on public and private boards, advisory groups, and commissions, such as a friend who assists an individual appointed to a local advisory board.

- Support that enables an individual to locate and maintain a home, such as assistance in financial planning, moving utility hook-ups, managing home responsibilities, arranging for home modifications and repairs, making monthly payments, and purchasing home security devices such as beepers which are necessary to assure individual health and well-being. Financial support that constitutes a room and board expense is excluded from federal financial participation.

- Support that enables the individual to access and use community resources such as instruction in using transportation, translator and communication assistance, and companion services to assist the individual in shopping and other necessary activities of community life.

- Support that assists the individual in developing financial stability and security, such as assistance in arranging for disability related work incentives and plans for achieving self-support; general banking; assistance in beginning a business enterprise; personal and estate planning; balancing accounts; preparing income taxes; and recordkeeping.

- Support that enables the individual to exercise rights as a citizen, such as assistance in exercising civic responsibilities.

- Support that enables the individual to benefit from the participation of friends, relatives and advocates as part of the individual's program planning team. Reimbursement to support program planning team members shall be limited to the cost of the member's travel and subsistence to and from meetings, phone charges, and orientation/training. Travel and subsistence allowances shall be held to ceiling established by the Department for its employees.

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- Support, not to exceed \$2,000 per individual a year in State and Federal funding participation, that enables the individual or the family with whom the individual resides to maintain their private residence when no household member, landlord, and provider agency staff are able to perform routine home maintenance including: cleaning and laundry, meal preparation, ice/snow/leaf removal, and yard maintenance. All agency owned and leased settings are excluded from participation in this service as a separate activity. Maintenance in the form of upkeep and improvements to the individual's residence is excluded from federal financial participation.

- Support, that enables an individual to pursue a career by taking continuing educational courses, training and apprenticeship beyond high school. This service consists of the cost of the individual's tuition, instruction, books, supplies, and tutoring. Services shall be provided by an accredited college or university, technical or trade school, or by a qualified professional, artisan or tradesperson as part of an apprenticeship/or mentor program.

Services rendered under the waiver are not available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving services, to ensure that the service is not otherwise available under a program funded under the Education of the Handicapped Act, or Section 110 of the Rehabilitation Act of 1973.

- Support that enables an individual to visit with friends and family in the community, such as the support of a personal care worker.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in situations where the recipient receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the habilitation services. When transportation is provided by an entity distinct from habilitation providers, the transportation can be paid directly to the provider of transportation services or on a subcontract basis by the habilitation provider.

Qualifications for providers of habilitation services are found in Appendix B-2.

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(4) Physical Adaptations (checked as Environmental Accessibility Adaptations on page 3)

Physical adaptations consist of certain modifications to the home or personal vehicle(s) of the person which are necessary due to the person's disability. Maximum state and federal funding participation is limited to \$20,000 per household, which includes adaptations to any personal vehicles used by the person/family while residing in that household. A new \$20,000 limit can be applied when the person moves to a new home. Physical adaptations consist of installation, repair and when necessary to comply with a rental/lease agreements, return of the property to its original condition.

Physical adaptations to a household subject to funding under this waiver are limited to the following items:

- ramps from street, sidewalk or house, including portable vehicle ramps
- handrails and grab-bars in and around the home
- that part of a smoke/fire alarm or detection system adapted for individuals with sensory impairments
- outside railing from street to home
- widened doorways, landings, and hallways
- kitchen counter, major appliance, sink and other cabinet modifications
- bathroom modifications for bathing, showering, toileting and personal care needs
- bedroom modifications of bed, wardrobe, desks, shelving, and dressers
- workroom modifications to desks and other working areas
- stair glider and elevating system
- climate and environmental control modifications prescribed by a physician

environmental accessibility adaptations to household vehicles are limited to the following:

- vehicular lifts
- interior alteration such as seats, head and leg rests, belts
- customized devices necessary for the individual to be transported safely in the community, including driver control devices

physical adaptations which cost \$10,000 or less, or major physical adaptations costing between \$10,001 and \$20,000, may be amortized or expensed. A major adaptation shall be used within the county MH/MR program for at least five years. if the major adaptation is not used for 5 years, part of the physical adaptation(s) funded by the Department, proportionately equal to the remaining unused time in the 5 year period, shall be refunded by the County to the Department, which will in turn adjust its claim for Federal Financial Participation by this same amount, unless the adaptation is utilized by another waiver recipient for the remaining unused time.

All adaptations to the household shall be provided in accordance with applicable building codes. All adaptations to vehicles will be provided by qualified individuals. Durable medical equipment is excluded.

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5. X **Permanency Planning Services**

Permanency planning services are a set of activities specified in the individual program plan which are designed to assist children who are 18 years of age or younger to live in families that offer continuity of relationships with nurturing parents and caregivers and the opportunity to maintain lifelong relationships.

Permanency planning activities consist of:

- identification of minor children in ICFs/MR, other residential settings, and living with their family who are lacking a permanent family relationship or who are at risk of ICF/MR placement.
- assessment of children and families to determine the conditions, if any, under which family reunification and permanency can occur.
- development of a permanency plan with the birth family, or if this is not possible and in the best interest of the child, with extended family, an adopted family or a host family.
- preparation of families and the child for permanency, including a home study.
- liaison with local agencies, the school system, and the court to arrange adoptions or other permanency arrangements.
- post-adoption or permanency support for up to one year after an adoption or other permanency arrangement is made.

Federal financial participation is excluded when services are available under Title IV-E of the Subsidized Adoption Act.

The provision of this service is needed to prevent institutionalization of the individual receiving services. Qualifications of providers of this service are included in Appendix B-2. The cost effectiveness of this service is demonstrated in Appendix G.

6. X **Therapy and Visiting Nurse Services (Visiting nurse checked as private duty nurse on page 3)**

Therapy services are provided by health care professionals which enable individuals to increase or maintain their ability to perform activities of daily living. Therapy services consist of:

1. Physical therapy provided by a licensed physical therapist based on documentation or a prescription for a specific therapy program by a physician.

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2. Occupational therapy by a registered occupational therapist based on documentation or a prescription for a specific therapy program by a physician.
3. Speech/language therapy provided by a licensed speech therapist or certified audiologist upon examination and recommendation by a certified or certification-eligible audiologist or a licensed speech therapist.
4. Visual/mobility therapy provided by a trained visual or mobility specialist/instructor based on an evaluation and recommendation by a trained mobility specialist/instructor.
5. Behavior therapy provided by a licensed psychologist or psychiatrist based on an evaluation by a licensed psychologist or psychiatrist.
6. Visiting nurse services provided by a registered nurse or a licensed practical nurse based on a prescription by a physician for a specific program or therapeutic regimen.

Providers of therapy services deliver services directly to the individual receiving services and/or supervise others who are assigned to assist in the administration of a particular therapeutic regimen. The provider of specialized services may also be responsible for ensuring that others assigned to provide this assistance receive appropriate supervision, orientation and training.

The need for therapy services will be documented by a written assessment by a qualified professional in the individual's program plan. These assessments are also subject to federal and state financial participation under the waiver.

The County mental health and mental retardation program is responsible to ensure that each provider meets applicable qualifications and that documentation of the provider's qualifications is maintained.

Therapy services do not duplicate services under the State plan due to difference in scope, frequency and duration of services and/or to specific provider experience and training required to accommodate the individual's disability. The following state plan services are excluded from Federal financial participation under the waiver:

- a. physician and dental services
- b. drugs

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- c. medical supplies
- d. outpatient hospital services
- e. clinic and rural health clinic services
- f. laboratory and radiological services
- g. family planning services
- h. EPSDT
- i. home health services

This service is necessary to prevent the institutionalization of the individual receiving services. The cost-effectiveness of the service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

7. X Transportation Services

Transportation Services are offered in order to enable individuals receiving services to gain access to waiver and other community services and resources specified in the individual plan. Transportation services consist of:

1. Purchase or leasing of provider agency vehicles for transporting individuals receiving waiver services. These costs are prorated by the usage for individuals receiving waiver services when vehicles are also used for accessing services and resources for individuals who are not waiver recipients. Purchase and leasing of personal vehicles for individuals and families are excluded.
2. Agency insurance, maintenance, and operational expenses of agency and agency staff vehicles used in the provision of services. These costs are prorated by the usage for individuals receiving waiver services when vehicles are also used for accessing services and resources for individuals who are not waiver recipients.
3. Reimbursement for mileage to providers, family members and other licensed drivers in using their personal vehicles to transport the individual to services specified in the individual's program plan. The reimbursement does not exceed the reimbursement rate established for DPW employees for such purposes. Mileage reimbursement to providers is limited to situations where transportation costs are not included in the provider's rate for services. Whenever possible, family, members, friends and community agencies which can provide this service without charge will be utilized.

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4. Reimbursement for use of emergency vehicles such as ambulances, when not covered through another funding source.

By enabling individuals receiving services to gain access to community services, institutionalization can be avoided. Qualifications of the providers of these services are included in Appendix B-2. The cost-effectiveness of these services are demonstrated in Appendix G.

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Appendix B-2
PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administration Code are referenced by citation. Standards not addressed under uniform State citation are attached.

| SERVICE | PROVIDER | LICENSE | CERTIFICATION | OTHER STANDARD* |
|------------------------|------------------------|--|--|--|
| Community Habilitation | Licensed Residential | 5 Pa. Codes Chapters 6400, 6500 Other DPW or Dept. of Aging | | <ul style="list-style-type: none"> - 10 or fewer residents in licensed MR settings established prior to January 1, 1996. - 4 or fewer residents in licensed MR settings established on or after January 1, 1996. - Standard of a contiguous state - Ten or fewer residents in a community home converted from ICF/MR. - Other state licensed or certified home of 10 beds or less |
| Community Habilitation | Unlicensed Residential | | Non-licensed Service Providers 1. 18 yrs. of age 2. Completion of necessary pre/in-service training based on individual program plan. 3. Agreement to carry out habilitation responsibilities based on the individual's program plan. 4. State clearance for child abuse/criminal history. | |
| Community Habilitation | Other Unlicensed | | Non-licensed Service Providers 1. 18 yrs. of age 2. Completion of necessary pre/in-service training based on individual program plan. 3. Agreement to carry out habilitation responsibilities based on the individual's program plan. | - Standard of a contiguous state approved by Regional Office of MR. |

*All services must conform to the County MH/MR Program Fiscal Manual, 55 Pa. Code Chapter 4300, and conditions of the County Agreement for waiver services with the Department.

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| SERVICE | PROVIDER | LICENSE | CERTIFICATION | OTHER STANDARD* |
|------------------------|------------------------|---|--|---|
| Community Habilitation | Adult Day Services | 55 Pa. Code Chapter 2380 6 Pa. Code Chapter 11 | Non-licensed Service Provider 1. 18 yrs. of age 2. Completion of necessary pre/in-service training based on individual program plan. 3. Agreement to carry out habilitation responsibilities based on the individual's program plan. | - Standard of a contiguous state approved by Regional Office of Mental Retardation (OMR). |
| Community Habilitation | Prevocational Services | 55 Pa. Code Chapter 2390 | Non-licensed Service Providers 1. 18 yrs. of age 2. Completion of necessary pre/in-service training based on individual program plan. 3. Agreement to carry out habilitation responsibilities based on the individual's program plan. | - Standard of a contiguous state approved by Regional OMR. |
| Community Habilitation | Supported Employment | | Non-licensed Service Providers 1. 18 yrs. of age 2. Completion of necessary pre/in-service training based on individual program plan. 3. Agreement to carry out habilitation responsibilities based on the individual's program plan. | - Standard of a contiguous state approved by Regional OMR. |
| Respite Services | Respite Services | | Non-licensed Service Providers 1. 18 yrs. of age 2. Completion of necessary pre/in-service training based on individual program plan. 3. Agreement to carry out habilitation responsibilities based on the individual's program plan. 4. State clearance for child abuse/criminal history. | 55 Pa. Code Chapter 6350 |

*All services must conform to the County MH/MR Program Fiscal Manual, 55 Pa. Code Chapter 4300, and conditions of the County Grant Agreement for waiver services with the Department.

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DATE: Effective 7/1/01

| SERVICE | PROVIDER | LICENSE | CERTIFICATION | OTHER STANDARD* |
|---------------------|----------------------|--------------------------------|------------------------------------|-----------------|
| Specialized Therapy | Physical Therapy | Physical Therapist* | | |
| Specialized Therapy | Occupational Therapy | | Registered Occupational Therapist* | |
| Specialized Therapy | Speech/Language | Speech Therapist* | Audiologist | |
| Specialized Therapy | Behavior | Psychologist* Psychiatrist* | | |
| Specialized Therapy | Visiting Nurse | Practical Nurse* | 1. Registered Nurse | |

* Standards for these professionals are established by the state Office of Professional Licensing and Certification. Copies of actual requirements are available on request.

** All services must conform to the County MH/MR Fiscal Manual, 55 Pa. Code Chapter 4300 and conditions of the County Grant Agreement for waiver services with the Department.

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| SERVICE | PROVIDER | LICENSE | CERTIFICATION | OTHER STANDARD* |
|----------------------|--|--|---------------|---|
| Physical Adaptations | Physical Adaptations | When required by Local/State Codes | | Applicable local or state building codes will be applied, when applicable, for minor physical adaptations. |
| Permanency Planning | Adoption Agency Case Management Provider | 55 Pa. Code Chapter 3350 | | Case management agencies meet DPW standards 55 Pa. Code 6201 |
| Transportation | All | State drivers license for type of vehicle used in service. | | Current inspection and insurance coverage as required by the state Department of Transportation. State vehicle registration. |
| | | | | |
| | | | | |

*All services must conform to the County MH/MR Program Fiscal Manual, 55 Pa. Code Chapter 4300, and conditions of the County Grant Agreement for waiver services with the Department.

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APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

a. KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. APPLICABILITY OF KEYS AMENDMENT STANDARDS

Check one:

- Home and community-based services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.
- A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

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B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure of certification requirements are met for services for individuals furnishing services that are provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

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Attachment

HCFA #0147.90 – Replacement of Pages 28-34(b)(1) Current Waiver Application

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

- 1. AFDC recipients.
- 2. SSI recipients (SSI Criteria States and 1634 States).
- 3. Aged, blind or disabled in 209(b) States who are eligible under §435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
- 4. Optional State supplement recipients
- 5. Optional categorically needy aged and disabled who have income at (Check one):
 - a. 100% of the Federal poverty level (FPL)
 - b. Percent of FPL which is lower than 100%
- 6. The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Check one:

- a. The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or:

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b. X Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) X A special income level equal to:

X 300% of the SSI Federal benefit (FBR)

___ % of FBR, which is lower than 300% (42CFR 435.236)

\$ ___ which is lower than 300%

(2) ___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) X Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4) ___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5) ___ Aged and disabled who have income at:

a. ___ 100% of the FPL

b. ___ % which is lower than 100%

(6) ___ All other mandatory and optional groups under the plan are included.

(7) ___ Other (Include statutory reference only to reflect additional groups included under the State Plan.)

Spousal impoverishment rules are used in determining eligibility for this special home and community-based waiver group at 42 CFR 435.217.

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7. X Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. X All other mandatory and optional groups under the plan are included.

9. _____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

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Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and needed home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: It may use the spousal post-eligibility rules under §1924.

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REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735

The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--§1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (Protection Against Spousal Impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

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Therefore, states which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal rule may use as the personal needs allowance the maintenance amount which the state has elected for home and community-based services waiver participants who do not have community spouses.

NOTE: If the state elects to use the institutional PNA, it must demonstrate that this is a reasonable amount to cover the cost of the individual's maintenance needs in the community (see OPTION 2).

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction of the following amounts from the waiver recipient's income.

A. 42 §435.726--states which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual:(Check one):

A. The following standard included under the State plan (check one):

(1) SSI

(2) Medically needy

(3) The special income level for the institutionalized

(4) The following percent of the Federal poverty level): %

(5) Other (specify):

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B. ___ The following dollar amount:

\$ _____ *

* If this amount changes, this item will be revised.

C. X The following formula is used to determine the needs allowance:

300% of the Federal SSI benefit rate.

Note: If the amount protected for waiver recipients in item 1 is **equal to, or greater than** the maximum amount of income, a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2 and 3** following.

2. Spouse only (check one):

A. ___ SSI standard

B. ___ Optional State supplement standard

C. ___ Medically needy income standard

D. ___ The following dollar amount: \$ _____ *

*If this amount changes, this item will be revised.

E. ___ The following percentage of the following standard that is not greater than the standards above: _____ % of standard.

F. ___ The amount is determined using the following formula:

G. X Not applicable (N/A)

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3. Family (check one):

A. AFDC need standard

B. AFDC payment standard

C. Medically needy income standard

D. The following dollar amount:
\$ _____*

*If this amount changes, this item will be revised.

E. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

F. The amount is determined using the following formula:

G. Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

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POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1. (b) 209(b) State, a State that is using more restrictive eligibility requirements than SSI.

The State is using the post-eligibility rules at 42 CFR 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction of the following amounts from the waiver recipient's income.

B. **42 CFR 435.735**--States using more restrictive requirements than SSI.

a) Allowances for the needs of the

(1) individual:(check one):

A. The following standard included under the State plan (check one):

(1) SSI

(2) Medically needy

(3) The special income level for the institutionalized

(4) The following percentage of the Federal poverty level: %

(5) Other (specify):

B. The following dollar amount: \$ *

* If this amount changes, this item will be revised.

C. The following formula is used to determine the amount:

***Note:** If the amount protected for waiver recipients in 1 is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2 and 3** following.

(2) Spouse only (check one):

A. The following standard under 42 CFR 435.121:

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B. ___ The medically needy income standard _____;

C. ___ The following dollar amount: \$ _____ *

*If this amount changes, this item will be revised.

D. ___ The following percentage of the following standard that is not greater than the standards above: _____% of _____

E. ___ The following formula is used to determine the amount:

F. ___ Not applicable (N/A)

(3) Family (check one):

A. ___ AFDC need standard

B. ___ AFDC payment standard

C. ___ Medically needy income standard

D. ___ The following dollar amount: \$ _____ *

*If this amount changes, this item will be revised.

E. ___ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

F. ___ The amount is determined using the following formula:

G. x Not applicable (N/A)

b) Medical and remedial care expenses specified in 42 CFR 435.726.

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ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

1. The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

For deinstitutionalized individuals.
Discharge planning team

Physician (M.D. or O.D.)

Registered Nurse, licensed in the State

Licensed Social Worker

Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a).

Other (specify):

For Diverted individuals:

Physician (M.D. or O.D.)

Registered Nurse, licensed in the State

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Licensed Social Worker

Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

Other (specify):

2. Initial evaluation of level of care is performed for waiver and institutionalized individuals through a common Pre-Admission Screening (PAS) system

a. Yes

b. No

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APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the recipient will take place (at a minimum) according by the following schedule (specify):

- every 3 months
- every 6 months
- every 12 months
- other (specify):

b. QUALIFICATIONS OF EVALUATORS PERFORMING REEVALUATIONS

Check one:

The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care. (Specify.)

- Physician (M.D. or D.O.)
- Registered Nurse, licensed in the State
- Licensed Social Worker
- Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

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APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (check all that apply):

- By the Medicaid agency in its central office.
- By the Medicaid agency in district/local offices.
- By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program.
- By the case managers.
- By the person(s) or agencies designated as responsible for the performance of evaluations and reevaluations.
- By service providers.
- Other (specify):

The responsible County MH/MR Program

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment criteria to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

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APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING ([To view the bulletin on this topic click here](#))

1. When a recipient is determined to be likely to require a level of care indicated in item 2 of this request, the recipient or his her legal representative will be:
 - a. informed of any feasible alternatives under the waiver; and
 - b. given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice or the provider(s) of their choice.
3. A copy of the form(s) used to document freedom of choice and to offer a fair hearing is attached to this Appendix. Also attached to this Appendix is a description of the agency's procedure(s) for informing eligible recipients (or their legal representatives) of the feasible alternatives available under the waiver and allowing recipients to choose either institutional or home and community-based services, and the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained: The County MH/MR
program or designee.

APPROVED: _____

DATE:

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. Identify the individuals responsible for the preparation of the plans of care.

Registered nurse, licensed to practice in the State.

Licensed practical or Vocational nurse, acting within the scope of practice under State law.

Physician (M.D. or D.O.) licensed to practice in the State.

Social Worker (qualifications attached to this Appendix.)

Service Manager.

Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

At the Medicaid agency central office.

At the Medicaid agency county/regional offices>

By case managers.

By the agency specified in Appendix A.

Other (specify): County MH/MR Program or designee.

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APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the individual program plan is made subject to the approval of the Medicaid agency:

The County MH/MR Program, as the agent of the Department, is responsible for approval of the individual program plan by its authorization of home and community services. The Regional Office of Mental Retardation also conducts periodic reviews of County MH/MR Programs which include reviews of individual program plans.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The individual program plan will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. There is no prescribed individual program plan format. County MH/MR Programs are responsible to ensure that the individual program plan meets Federal and State requirements in accordance with the conditions of its Annual Supplemental Grant Agreement with Department policy which is currently MR Bulletin 00-92-23 titled: County Responsibilities for Waiver Case Management.

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DATE:

STATE: PENNSYLVANIA

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

Payment for waiver services will not be made through an approved MMIS. A description of the process by which payment are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

Other (Describe in detail):

APPROVED: _____

DATE:

STATE: PENNSYLVANIA

1. (Attachment)

Payment for waiver services will be made to the provider of services by the County MH/MR Program with funds made available by the Department through appropriation by the State legislature.

The County is required to make payments to providers for Waiver funded services within the amounts established in the County's waiver allocation(s) based on a cost report for billing which serves as the provider's billing for MA eligible services.

Payments are based on individually negotiated rates or charges between the provider and the County MH/MR Program in accordance with 55 PA Code 4300.

The county is required to ensure that the billings specify the name of the individual receiving services or an alternate unique recipient identifier, the name of the MA eligible services the individual receives, the number of actual units of MA eligible services provided during the report period, and the approved rate for services. The County MH/MR Program also ensures that services reported are approved in the individual's program plan, and that the individual meets eligibility requirements.

The County consolidates the service reports, including any adjustments, and completes a Department of Public Welfare quarterly report. This quarterly report is forwarded to the Department. The report identifies separate funding eligible for FFP. The County makes adjustments to its quarterly report to the Department based on its review of provider reports and notification of exceptions by the Department.

Annual reports are submitted by the County to the Department for waiver services following the close of each fiscal year. These reports reflect actual service costs and utilization reported by providers. Final reconciliation is contingent on receipt of actual provider audited costs, with any subsequent final adjustments made in the following year's reports. The annual reports are prepared in accordance with instructions and on forms provided by the Department.

Annual audits of County MH/MR programs and providers of service are in accordance with the Single Audit Act. Additional payment and fiscal safeguards are contained in the County's Annual Agreement with the Department.

The provider of service preserves books, documents, and records related to MA eligible services for three years after the MA eligible services are furnished.

APPROVED: _____

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The provider of services also retains records which relate to litigation or the settlement of claims arising out of the performance or expenditures to which exception has been taken by the auditors. These records are retained by the provider until such litigation, claims, or exceptions have reached final disposition.

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

- a. When the client was eligible for Medicaid waiver payment on the data of service;
- b. When the service was included in the approved plan of care;
- c. In the case of supported employment, prevocational or education services included as part of habilitation services, when the individual was eligible to receive the services, and the services are not available to the client through a program funded under Section 602(16) or (17) of the Education of Handicapped Act (P.L. 94-142) or Section 110 of the Rehabilitation Act of 1973, as amended by IDEA.

 X yes.

 no. These services are not included in the waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

 All claims are processed through an approved MMIS.

 X MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

APPROVED: _____

DATE: _____

STATE: PENNSYLVANIA

2. **(Attachment)**

The provider of service preserves books, documents, and records related to MA eligible services for three years after the MA eligible services are furnished.

The provider of services also retains records which relate to litigation or the settlement of claims arising out of the performance or expenditures to which exception has been taken by the auditors. These records are retained by the provider until such litigation, claims, or exceptions have reached final disposition.

APPROVED: _____

DATE:

STATE: PENNSYLVANIA

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G - FINANCIAL DOCUMENTATION

**APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA**

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

| YEAR | FACTOR D | FACTOR D' | FACTOR G | FACTOR G' |
|------|-----------------|----------------|------------------|----------------|
| 1 | <u>\$48,931</u> | <u>\$5,328</u> | <u>\$102,465</u> | <u>\$3,694</u> |
| 2 | <u>\$50,321</u> | <u>\$7,224</u> | <u>\$106,564</u> | <u>\$3,842</u> |
| 3 | <u>\$50,759</u> | <u>\$7,229</u> | <u>\$110,827</u> | <u>\$3,996</u> |
| 4. | <u>\$51,191</u> | <u>\$7,352</u> | <u>\$115,260</u> | <u>\$4,156</u> |
| 5 | <u>\$51,284</u> | <u>\$7,487</u> | <u>\$119,870</u> | <u>\$4,322</u> |

APPROVED: _____

DATE:

STATE: PENNSYLVANIA

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

| YEAR | UNDUPLICATED INDIVIDUALS |
|------|--------------------------|
| 1 | <u>14,587</u> |
| 2 | <u>15,493</u> |
| 3 | <u>16,268</u> |
| 4 | <u>17,081</u> |
| 5 | <u>17,935</u> |

EXPLANATION OF FACTOR C:

Check one:

The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPROVED: _____

DATE: _____

STATE: PENNSYLVANIA

**APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES**

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPROVED: _____

DATE: _____

STATE: PENNSYLVANIA

**APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD**

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, domiciliary care certified homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Habilitation
Physical Adaptations
Therapies and Visiting Nurse

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Habilitation
Physical Adaptations
Therapies and Visiting Nurse

The following is an explanation of the method used by the state to exclude Medicaid payment for room and board.

The county's signed supplemental grant agreement excludes room and board as an eligible service except as allowed by HCFA. Single Audit protocols review for the room and board exclusion.

APPROVED: _____

DATE: _____

**APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN
UNRELATED LIVE-IN CAREGIVER**

Check one:

The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

APPROVED: _____

DATE: _____

APPENDIX G-5

FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services **WHILE THE INDIVIDUAL WAS ON THE WAIVER.**

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began **AFTER** the person's first day of waiver services and ended **BEFORE** the end of the waiver year **IF** the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred **BEFORE** the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPROVED: _____

DATE: _____

APPENDIX G-5

FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

Based on HCFA Form 2082 (relevant pages attached).

Based on HCFA Form 372 for years 1998/1999 of waiver # 0147.90, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

Other (specify):

APPROVED: _____

DATE: _____

STATE: PENNSYLVANIA

APPENDIX G-6

FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

Based on trends shown by HCFA Form 372 for years 1998-1999 of waiver #0147.90, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached (see prior page attachment for 11 ICF/MR recipients).

Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its cost under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPROVED: _____

DATE: _____

STATE: PENNSYLVANIA

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPROVED: _____

DATE: _____

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

Factor G' is computed as follows (check one):

Based on HCFA Form 2082 (relevant pages attached).

Based on HCFA Form 372 for years 1998-1999 of waiver #0147.90, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

Other (specify):

APPROVED: _____

DATE: _____

STATE: PENNSYLVANIA

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

YEAR 1

FACTOR D: \$48,931

FACTOR G: \$102,465

FACTOR D': \$ 5,328

FACTOR G': \$ 3,694

TOTAL: \$54,259 ≤

TOTAL: \$106,159

YEAR 2

FACTOR D: \$52,419

FACTOR G: \$106,564

FACTOR D': \$ 5,541

FACTOR G': \$ 3,842

TOTAL: \$57,960 ≤

TOTAL: \$110,406

YEAR 3

FACTOR D: \$52,143

FACTOR G: \$110,827

FACTOR D': \$ 5,763

FACTOR G': \$ 3,996

TOTAL: \$57,906 ≤

TOTAL: \$114,823

Value G calculation: \$94,735 for FY 1998/99 x 2 COLAs of 4%
Value D' calculation: \$4,926 for FY 1998/99 x 2 COLAs of 4%
Value G' calculation: \$3,415 for FY 1998/99 x 2 COLAs of 4%

APPROVED: _____

DATE: _____

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC: ICF/MR

YEAR 4

FACTOR D: \$52,368

FACTOR G: \$115,260

FACTOR D': 5,994

FACTOR G': \$ 4,156

TOTAL: \$58,362 ≤

TOTAL: \$119,416

YEAR 5

FACTOR D: \$52,397

FACTOR G: \$119,870

FACTOR D': \$ 6,234

FACTOR G': \$ 4,322

TOTAL: \$58,631 ≤

TOTAL: \$124,192

Value G calculation: \$94,735 for FY 1998/99 x 2 COLAs of 4%

Value D' calculation: \$4,926 for FY 1998/99 x 2 COLAs of 4%

Value G' calculation: \$3,415 for FY 1998/99 x 2 COLAs of 4%

APPROVED: _____

DATE: _____