

Side-by-Side Comparison of Current Language and Proposed Changes for Consolidated and P/FDS Waivers

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		<p>reports and review provider financial audits, as per the AE Operating Agreement.</p> <ul style="list-style-type: none"> • Using the ODP quality structure AEs develop and implement a written quality management plan as per the AE Operating Agreement. • Participating in ODP required training as per the AE Operating Agreement. 				

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3	Appendix A.6 Assessment Methods and Frequency	Describes the ODP oversight and monitoring process which includes. The description includes the requirement for DPW's Bureau of Hearings and Appeals (BHA) to receive a distribution of service review findings of fair hearing requests and requires AEs to develop QM plans as part of the monitoring process.	<ul style="list-style-type: none"> • Remove the requirement for AEs to develop a QM plan. • Remove the requirement for BHA to receive a distribution of service review findings of fair hearing requests. • Add requirement for SCOs to receive service findings from fair hearing requests. • Provide greater clarity regarding the components of the ODP monitoring process. <ul style="list-style-type: none"> – Specify that the AE Oversight Monitoring Process (AEOMP) is a standardized process designed to collect, compile and analyze data to monitor that the functions delegated to the AEs are being performed in compliance with all ODP requirements including waiver assurances and administrative functions delegated to them by ODP through the AE Operating Agreement. – Describe that AE compliance is determined based upon review of specific areas: delegated functions; eligibility/level of care; due process; service plans-timeliness content and use of ODP issued ISP Signature Page; and provider qualifications and monitoring. – Specify that AEOMP is implemented on a staggered basis, with a formal on-site review of each AE annually. <ul style="list-style-type: none"> – Clarify the role of incident management to determine individual health and welfare in the monitoring process. – Clarify the role of the Regional Office risk management workgroup (and risk management forums in the monitoring process. – Add language regarding ODP review of service plans for prior authorization. 	The role of incident management is to determine and ensure health and welfare.	ACHIEVA	1.12.2012

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4	Appendix A Quality Improvement: Administrative Authority of the Single State Medicaid Agency	Describes the State's quality improvement strategy (QIS) to ensure appropriate administration and oversight of the program.	<p>The QIS has been extensively rewritten. The following are the revised performance measures. The QIS in its entirety is included in Attachment A.</p> <ul style="list-style-type: none"> • Number and percent of AEs that implement monitoring protocols. Percent = number of AEs that implement monitoring protocols/number of AEs that delegate or purchase administrative functions. • Number and percent of AEs that maintain, safeguard, and provide access to waiver records as per ODP's expectations. Percent = number of AEs that maintain, safeguard and provide access to waiver records as per ODP's expectations/number of AEs reviewed. • Number and percent of waiver participants whose category of need for services is reviewed/updated in accordance with the Department's policy and form (currently PUNS). Percent = number of waiver participants whose category of need for services is reviewed/updated in accordance with the Department's policy and form (currently PUNS)/number of waiver participants reviewed. • Number and percent of eligible applicants having an emergency need (the individual has current needs or anticipated needs within the next six months) who receive preference in waiver enrollment. Percent = number of eligible applicants having an emergency need who receive preference in waiver enrollment/number of eligible applicants. • Number and percent of waiver participants issued fair hearing and appeal rights in accordance with policies and procedures. Percent = number of waiver participants issued fair hearing and appeal rights in accordance with policies and procedures/number of waiver participants reviewed. • Number and percent of final orders issued by the Department's Bureau of Hearings and Appeals ruled in favor of the appellant and implemented within 30 calendar days of the final order. Percent = number of final orders issued by the Department's Bureau of Hearings and Appeals ruled in favor of the appellant 	In the event that 100% is not achieved on a performance measure, the reason needs to be documented.	ACHIEVA	1.12.2012

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			<p>and implemented within 30 calendar days of the final order/number of final orders issued by the Department's Bureau of Hearings and Appeals ruled in favor of the appellant.</p> <ul style="list-style-type: none"> • Number and percent of AEs that qualify providers using qualification criteria as outlined in the current approved waiver. Percent = number of AEs that qualify providers using qualification criteria as outlined in the current approved waiver/number of AEs reviewed. • Number and percent of AEs that monitor providers using the monitoring processes developed by ODP. Percent = number of AEs that monitor providers using the monitoring processes developed by ODP/number of AEs reviewed. 			
Appendix B: Participant Access and Eligibility						
5	Appendix B-3.a	<p>The section notes the number of individuals served for each year of the waiver.</p> <p>Consolidated Waiver Year 1: 16942 Year 2: 17559 Year 3: 17619</p>	<p>Revise the number of individuals served in the waiver renewals as follows:</p> <p>Consolidated Waiver Year 1: 16887 Year 2: 17057 Year 3: 17117</p>	<p>The revised numbers reflect a substantial decrease in the number of individuals ODP plans to serve. Given the the increasing number of elderly caregivers who are desperately in need of critical services and the annual population of graduates, we recommend that ODP not lower the</p>	ACHIEVA	1.12.2012

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		Year 4: 17646 Year 5: 17646 P/FDS Waiver Year 1: 10739 Year 2: 12045 Year 3: 12045 Year 4: 12045 Year 5: 12045	Year 4: 17232 Year 5: 17347 P/FDS Waiver Year 1: 11200 Year 2: 11200 Year 3: 11200 Year 4: 11200 Year 5: 11200	maximum number of participants who will be served with a waiver.		
6	Appendix B-3.c Reserved Waiver Capacity	The waivers currently do not allow for reserved capacity for specific purposes.	In order to reflect current practice, update the waivers to allow for reserved capacity for the following: <ul style="list-style-type: none"> • Waiver participants requiring medical/rehabilitation care beyond 30 days up to 6 months from the first date of leave. (P/FDS and Consolidated). • Unanticipated emergency situations identified by AEs requiring waiver enrollment.(Consolidated). • New waiver enrollees leaving State ICF/MR facilities for community programs via Money Follows the Person Initiative. (Consolidated). Reserved capacity numbers for the Consolidated Waiver renewal are as follows: Year 1: 190 Year 2: 140 Year 3: 140 Year 4: 115 Year 5: 105 Reserved capacity numbers for the P/FDS Waiver renewal are as follows: Year 1: 25 Year 2: 25 Year 3: 25 Year 4: 25 Year 5: 25	Given that the Benjamin Settlement mandates the transition of between 50-75 people from state centers each year, in Years 2-5, the reserved capacity leaves limited capacity for waiver participants experiencing medical care and/or unanticipated emergencies.	ACHIEVA	1.12.2012

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7	Appendix B-3.d Allocation of Waiver Capacity	Waiver capacity is allocated based upon historical usage. Each AE receives an annual commitment letter that outlines their assigned capacity.	<ul style="list-style-type: none"> Revise waiver capacity allocation so that it is based on the size of the AE. Additional waiver capacity is committed based on information captured through the standardized PUNS form. Current enrollment in the AE jurisdiction and expected need for access based on review of PUNS across the State. 			
8	Appendix B-3.f Selection of Entrants to the Waiver	Describes the role of AEs in enrolling individuals into the waiver, including the requirement that individuals assessed as having an emergency preference for waiver funding, as identified through PUNS, should be given priority placement into the waiver.	Clarify that: <ul style="list-style-type: none"> Services should begin within 45 calendar days of waiver enrollment. ODP retains ultimate authority to select waiver applicants for waiver enrollment based on an applicant's emergency circumstance. 	In the event that ODP grants approval for services to begin after 45 days, this approval needs to be in writing and forwarded to the waiver participant.	ACHIEVA	1.12.2012
9	Appendix B-6.a.ii Frequency of Services	At least one waiver service must be provided each calendar month with the following exceptions: <ul style="list-style-type: none"> The waiver participant is admitted to a medical facility (for example, hospital, rehabilitation facility, The provider is unable to provide services for that period of time due to provider service and provide a detailed corrective action plan to address such situations in the future. There must also be documentation that the choice of other qualified providers has been offered to the participant; or The waiver participant living at home requires an emergency relocation (for example, due to a fire) and is unable to access waiver services for up to 45 calendar days. 	Limit the exceptions to one waiver service each calendar month to the following: <ul style="list-style-type: none"> The waiver participant is admitted to a medical facility (for example, hospital, rehabilitation facility, nursing home) for up to 45 calendar days). The waiver participant living at home requires an emergency relocation (for example, due to a fire) and is unable to access waiver services for up to 45 calendar days. 			
10	Appendix B-6.c Responsibility for Performing	Allows for level of care evaluations/reevaluations by AE staff and supports coordinators as long as these persons meet the QMRP requirements and are not	Prohibits QMRPs of supports coordination entities from conducting level of care evaluations/reevaluations (even if they are not directly involved in the provision of service			

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	Evaluations and Reevaluations	directly involved in the provision of service for the individual.	for an individual).			
11	Appendix B Quality Improvement: Level of Care	Describes the State's QIS to ensure the appropriateness and timeliness of level of care (LOC) determinations and re-determinations.	<p>The QIS has been extensively rewritten. The following are the revised performance measures. The QIS in its entirety is included in Attachment A.</p> <ul style="list-style-type: none"> • Number and percent of new enrollees who have a LOC completed prior to entry into the waiver. Percent = number of new enrollees who have a LOC completed prior to entry into the waiver/number of new enrollees. • Number and percent of annual LOC redeterminations completed within 365 days of the prior review. Percent = number of LOC redeterminations completed within 365 days of the prior review/number of redeterminations that are due. • Number and percent of LOC initial determinations and redeterminations completed according to ODP policies and procedures. Percent = number of LOC initial determinations and redeterminations completed according to ODP policies and procedures/number of LOC determinations and redeterminations reviewed. • Number and percent of initial LOC determinations and redeterminations that were completed accurately. Percent = number of initial LOC determinations and redeterminations that were completed accurately/number of LOC determinations and redeterminations reviewed. 	In the event that LOC determinations and re-determinations are not completed in the specified timeframes, reasons need to be stated in writing.	ACHIEVA	1.12.2012
Appendix C: Participant Services						
	Appendix C-1/C-3	General Changes Covering Multiple Services				
12		<ul style="list-style-type: none"> • Language did not clearly indicate that individuals must utilize their state plan benefits before accessing services through the waiver. 	<ul style="list-style-type: none"> • Clarify that services are only available through the waiver to the extent that they are not otherwise available to individuals through medical assistance. 			
13		<ul style="list-style-type: none"> • Prior versions of the waiver used term "mental retardation" throughout document 	<ul style="list-style-type: none"> • Consistently use the term "intellectual disability" throughout the waiver. 			
14		<ul style="list-style-type: none"> • All details of operation were historically contained in the waiver itself. Change necessary 	<ul style="list-style-type: none"> • Add applicable regulatory citations (referencing applicable new sections/chapters) 			

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		to reflect the newly effective regulatory provisions.				
15		<ul style="list-style-type: none"> Provider verification schedule previously required annual recertification. 	<ul style="list-style-type: none"> Change provider qualification verification schedule to two years or more frequent if determined necessary by ODP. 			
16		<ul style="list-style-type: none"> Circumstances under which non-Pennsylvania-based providers could render services was not clearly described. 	<ul style="list-style-type: none"> Clarify the circumstances under which providers not located within Pennsylvania may render services (contiguous state). Specifically, language indicates that a service may be rendered by an entity located in a contiguous state. 			
17		<ul style="list-style-type: none"> Criteria for accessing enhanced levels of service were not clearly identified in previous waiver versions. 	<ul style="list-style-type: none"> Specify that, for those services that provide for enhanced level of services, the provision of the enhanced level must be tied directly to an identified need of the individual requiring the enhanced level of service and the specific need for a higher qualification of staff. 			
18		<ul style="list-style-type: none"> Entities responsible for verification of provider qualifications were not clearly/consistently identified. 	<ul style="list-style-type: none"> Changes made to indicate that ODP or designee verify provider qualifications throughout services. 			
	Appendix C1/C3 Provider Specifications for Service	Service-Specific Changes		To meet the communication needs of waiver participants who are deaf, deaf-blind or hard of hearing, current service definitions must be modified to include sign language interpreters, sign fluent staff, and other accessible communication services. For people who are blind or visually-impaired, service definitions must be modified to address their specialized communication needs. Market driven rates for these specialized services must be available and authorized.	ACHIEVA	1.12.2012
19	Educational Support Services	Previous service specification did not include language indicating criteria for receipt of service.	Add language requiring that Educational Support Services must be provided only to individuals that have an identified employment outcome or other specific outcome for skill attainment or development in the ISP related to the Education Support Service need.	Educational support services must include instruction in ASL, Braille or other communication mode, either in a classroom or a tutor.	ACHIEVA	1.12.2012
20	Unlicensed HCBS Habilitation	<ul style="list-style-type: none"> Prior version included term "therapeutic services" Little guidance provided for those interested in 	<ul style="list-style-type: none"> Remove term "therapeutic services." Clarify parameters for individuals to choose this 	Enhanced level of service must include staff who are fluent in ASL and Braille.	ACHIEVA	1.12.2012

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		<p>using this service as an alternative to day/prevoc services.</p> <ul style="list-style-type: none"> Prior version did not explicitly indicate expectation that staff be awake for provision of services. 	<p>service as an alternative to licensed day habilitation or prevocational.</p> <ul style="list-style-type: none"> Clarify that staff must be awake while rendering this service. Clarify that the enhanced level of service must be tied to the individual's specific need for a higher qualification of staff. 	Add that habilitation may include the development of communication skills.	ACHIEVA	1.12.2012
21	Homemaker/Chore	Previous version indicated that service could be provided in a home. Did not define home.	Clarify that this service is available to individuals who reside in a private residence.			
22	Prevocational	Many references to vocational settings were included within the service specifications.	While the provider qualifications remain unchanged, removed vocational references within service specifications to ensure clearer definition of the pre-vocational service provided.			
23	Residential Habilitation	<ul style="list-style-type: none"> Prior waiver included a grandfathering provision related to size of home. Per CMS, grandfathering clause could not continue. Enhanced levels of service did not previously require specific review or identified needs. Language did not expressly provide expectations for home and community based settings. P/FDS Waiver Included Residential Habilitation 	<ul style="list-style-type: none"> Pursuant to guidance from CMS, clarified an across the board maximum for certain residential settings (8 or approved capacity). Indicate that enhanced level of service must be reviewed with regular periodicity (6 months). Clarify that enhanced level of service must be tied to an explicit, identified need. Clarify that settings must be dispersed throughout the community, in non-contiguous settings, not located on a campus. Remove residential habilitation from P/FDS waiver (low utilization of service) 	<p>Given that the inclusion of people with disabilities is best accomplished when they are supported to live and work in communities with their neighbors, we request that the current residential size limitation of four people be maintained.</p> <p>Enhanced level of service must include staff who are fluent in ASL and Braille.</p>	ACHIEVA	1.12.2012
24	Supported Employment	Language did not specify that assisting an individual to "obtain" employment was a permissible activity under the waiver.	Add "obtain" to service specification.			
25	Supports Coordination	<ul style="list-style-type: none"> Items were not previously included regarding ODP monitoring as a provider qualification. Expectation that info regarding participant direction being provided in advance of meeting was not explicitly included previously. 	<ul style="list-style-type: none"> Included successful completion of ODP annual monitoring process to provider qualifications. Clarified that the SC shares information with the individual regarding participant direction opportunities in advance of team meeting [to allow time for understanding options]. 	Clarity a reasonable amount of time in advance of a meeting that the SC must send written information about participant direction options to a waiver participant.	ACHIEVA	1.12.2012
26	Therapy Services	Criteria for receipt of service was not clearly identified previously.	Added language requiring that therapy services be medically necessary.	Clarify that communication specialists are medically necessary for waiver participants who are deaf , deaf-blind, hard of hearing,	ACHIEVA	1.12.2012

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27	Support Broker	<p>Prior approved definition:</p> <p><i>This is a direct (face-to-face) and indirect service to individuals with mental retardation in arranging for, developing, and managing the services they are self-directing through either employer authority (hiring/managing workers) or budget authority (determining worker salaries, shifting units and associated funds between approved services and/or providers). Services are provided to assist individuals in identifying immediate and long-term needs, developing community-based options to meet those needs, and accessing identified supports and Application for services. Services also involve practical skills training and information for individuals and surrogates related to directing and managing services. This service is limited to:</i></p> <ul style="list-style-type: none"> • <i>Assistance in identifying and sustaining a personal support network of family, friends, and associates to meet individual needs.</i> • <i>Assistance in arranging for and effectively managing generic community resources and informal supports to meet individual needs.</i> • <i>Assistance at planning meetings to ensure the individual's access to needed quality community resources.</i> • <i>In depth practical skills training for individuals and surrogates related to self-direction and management of qualified support service workers. Training is limited to employer responsibilities (e.g., hiring, managing, and terminating workers; reviewing and approving timesheets; problem solving; conflict resolution).</i> • <i>Assistance to the individual in managing, monitoring, and reviewing their participant directed services and associated funds.</i> 	<p>Significant changes (noted below) reflective of recommendations from Sub group of the SPT:</p> <p><i>Support Broker services are direct and indirect services available to individuals who elect to self direct their own services utilizing the VF/EA FMS or AWC FMS model. The Support Broker services enable individuals with intellectual disabilities to plan their own lives, exercise budget and employer authority to get the services and supports they need, be integrally involved in their community as they choose and be responsible for their own choices and decisions. The intent of Support Broker services is to enhance the individual's ability to direct their services. The Support Broker is committed to values that support each individual's right to live a life of dignity, be fully included in community life and be supported by the individual's chosen network of friends and family. Services are designed to provide assistance as needed with employer-related functions, planning, accessing community resources and service and support continuity and maintenance.</i></p> <p><i>Support Broker services are not standardized services delivered equally to each individual who need and chooses to use them. Instead the Support Broker activities will vary depending on the choice and needs of each individual who elect to direct services themselves or identify a surrogate to act as the common law employer or managing employer. Additionally, the intensity of support provided may range from teaching skills to performing a task for the individual or designated surrogate. The individual and when designated the individuals surrogate will make decisions and the determination of the duties required of the common law employer or managing employer. The activities of the Support Broker is uniquely defined by each individual. Individuals and their surrogates direct decisions and cannot be forced to accept Support Broker</i></p>	blind or visually impaired..		

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		<ul style="list-style-type: none"> • <i>Development of back-up plans in the event of emergencies and/or unexpected worker absences.</i> • <i>Train individual to help them recognize reportable incidents and help them report the incidents to the Supports Coordinator or provider as required.</i> • <i>Assistance with paperwork related to the individual's employer responsibilities as the employer of record or co-employer of support service workers.</i> • <i>Assistance with budgeting, including review and evaluation of monthly expenditure reports.</i> • <i>Provide detailed information and training to individuals about: person centered planning and how it is applied, risks and responsibilities related to self-direction, free choice of willing and qualified providers, individual rights and use of community and natural supports.</i> <p><i>Supports brokers must work collaboratively with the individual's supports coordinator. The role of the Supports Coordinator continues to involve the primary functions of locating, coordinating, and monitoring of waiver services; while the Supports Broker assists individuals and families with being able to self-direct their support. It is important to understand that each role is vital to the support of the individual and their family. It is also important to understand that Supports Coordinators also assist individuals and families with self-directing their support, however, not necessarily at the level of intensity that is needed by many.</i></p> <p><i>Supports Broker Services are different from Supports Coordination and Supports Brokers may not replace</i></p>	<p><i>recommendations. The Support Broker is not a surrogate decision-maker.</i></p> <p><i>Support Broker services are optional services and are based on an individuals need for the service. Individuals, the surrogate when designated and the team will choose whether or not to utilize the services of a Support Broker. Any mandatory functions are assigned to one of the existing roles (Financial Management Services Organization, Supports Coordinator etc.) and will not be performed by the Supports Broker.</i></p> <p><i>To support a participant to self-direct, duties performed by a Support Broker may include assistance with:</i> <i>Employer-Related Duties</i></p> <ul style="list-style-type: none"> • <i>Understanding and completing employer-or managing employer related paperwork</i> • <i>Participation in Financial Management Services (FMS) orientation</i> • <i>Effective hiring techniques including creating job descriptions, ads for hiring, strategies for evaluating candidates and informing candidate on selection or non-selection</i> • <i>Determining pay rates for workers</i> • <i>Providing or arranging for worker training</i> • <i>Developing worker schedules</i> • <i>Effective management and supervision techniques such as conflict resolution</i> • <i>Proper procedures for termination of workers in the VF/EA FMS option or communication with the Agency With Choice regarding the desire for removal of the workers from working with the individual in the AWC FMS option</i> • <i>Review of workplace safety issues and strategies for effective management of workplace injury prevention</i> • <i>Understanding and/or fulfilling the responsibilities outlined in the Common Law Employer Agreement</i> 			

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		<p><i>the role or perform the functions of a Supports Coordinator; no duplicate payments will be made.</i></p> <p><i>Supports Broker Services may not be provided by agency providers that provide other direct Waiver services or administrative services (for example, a Health Care Quality Unit or an Independent Monitoring Program).</i></p> <p><i>During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. The service may be provided on an ongoing basis by qualified providers based in Pennsylvania and states contiguous to Pennsylvania.</i></p> <p>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</p> <p><i>This service is limited to a maximum of 1040 units per individual per fiscal year based on a 52-week year. This service is limited to individuals who are self-directing their services through employer and/or budget authority.</i></p>	<p><i>form and the Managing Employer Agreement form</i></p> <p><i>Planning</i></p> <ul style="list-style-type: none"> • <i>Facilitation of a support group that helps to meet the participant's self direction needs</i> • <i>In-depth planning, including identifying a vision of the future and determining future goals for self direction</i> • <i>Identifying areas of support that will promote success with self direction and independence and share the information with the team and Supports Coordinator for inclusion in the Individual Support Plans</i> • <i>Communicating and negotiating any necessary modifications to the participant's Individual Support Plan</i> • <i>Developing, implementing and modifying a back-up plan for staffing for emergencies and/or worker absences</i> • <i>Advising and assisting individuals or the surrogate with the development of procedures to monitor expenditures and utilization of services</i> • <i>Scheduling paid and unpaid supports</i> <p><i>Service and Support Continuity and Maintenance</i></p> <ul style="list-style-type: none"> • <i>Compliance with the regulations, policies and the waiver requirements related to self direction</i> • <i>Advising in problem-solving, decision-making, and achieving desired outcomes</i> • <i>Developing, modifying and negotiating an individualized budget</i> <p><i>Other duties to Support Self-Direction</i></p> <ul style="list-style-type: none"> • <i>Performing activities to assist an individual to be successful in self-direction. Duties must be related to self direction outcomes in the Individual Support Plan</i> 			

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			<p><i>Support Brokers must work collaboratively with the individual's Supports Coordinator and team. The role of the Supports Coordinator continues to involve the primary functions of locating, coordinating, and monitoring of waiver services; while the Support Broker assists individuals and surrogates with being able to self-direct the individual's services and supports. It is important to understand that each role is vital to the support of the individual and their surrogate. It is also important to understand that Supports Coordinators provide information related to self-direction to individuals, families, and surrogates; however, Supports Coordinators do not assist individuals, families, and surrogates with the activities associated with self-direction. Support Broker Services are different from Supports Coordination. Support Brokers may not replace the role or perform the functions of a Supports Coordinator. No duplicate payments will be made.</i></p> <p><i>Supports Broker Services may be provided by agency provider that provide other Waiver services but the Supports Broker agency must be conflict free and may not provide other waiver services to the individual they agree to provide the Supports Broker services to. An AWC FMS may provide supports broker services to individuals and surrogates self directing services but only as a participant directed service through the AWC FMS provider type 54. The AWC may not offer supports broker as a Provider Type 26. Individual supports broker provides must be conflict free and may not provide supports broker services to any individual they provide other waiver service to.</i></p> <p><i>Supports Broker agency and individual providers may not provide administrative services (for example, a Health Care Quality Unit, Administrative Entity or an Independent Monitoring Program).</i></p> <p><i>During temporary travel, this service may be provide</i></p>			

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			Clarify that the addition of a new room is not permitted.			
31	Specialized Supplies	Did not specify that this service should be in addition to –not supplant - services available under the state plan.	Clarify that incontinence supplies are available only to the extent that they are not available to individuals through regular medical assistance.			
32	Home Finding	Consolidated and P/FDS included home finding. Low to no utilization.	Remove the service from both waivers (no existing utilization. Functions performed by other services).			
33	Transportation	<p>Service defined as follows:</p> <p><i>Direct services to provide transportation to enable individualsto access services and activities specified in their approved ISP. This includes transportation that is provided by Adult Training Facilities, Prevocational Service and Transitional Work Service providers who transport individualsto and from their homes and providers sites. It is not transportation that is an integral part of the provision of activities within Habilitation Services settings nor is it transportation associated with Residential Habilitation Services, as transportation in these situations is built into the rate for the habilitation service.</i></p> <p><i>Transportation services consist of:</i></p> <p>1. <i>Transportation (Mile). This transportation service is provided by providers, family members, and other licensed drivers. Transportation Mile is used to reimburse the qualified licensed driver who transports the individual to and from services and resources specified in the individual's ISP. The unit of service is one mile. Mileage will be paid round trip. The rate for this service is the current state rate for mileage reimbursement.</i></p>	<p>Significant changes made per guidance from CMS, including deletion of transportation per diem:</p> <p><i>Direct services to provide transportation to enable participants to access services and activities specified in their approved ISP. This service does not include transportation that is an integral part of the provision of another discrete waiver service, nor does it include transportation associated with Residential Habilitation Services, as transportation in these situations is built into the rate for the other waiver services. Transportation services must be provided in compliance with the minimum standards established by ODP.</i></p> <p><i>Transportation services consist of:</i></p> <p>1. <i>Transportation (Mile). This transportation service is delivered by providers, family members, and other licensed drivers. Transportation Mile is used to reimburse the owner of the vehicle or other qualified licensed driver who transports the participant to and from services and resources specified in the participant's ISP. The unit of service is one mile. Mileage will be paid round trip. A round trip is defined as from the point of first pick-up to the service destination and the return distance to the point of origin. When transportation is provided to more than one participant at a time, the provider will divide the shared miles equitably among the participants to whom transportation is provided. The provider is</i></p>			

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		<p><i>When transportation is provided to more than one individual at a time, the total number of units of service that are to be provided are equitably divided among the individuals for whom transportation is provided.</i></p> <p>2. <i>Public Transportation. Public transportation services are provided to or purchased for individuals to enable them to gain access to services and resources specified in their ISPs. The utilization of public transportation promotes self-determination and is made available to individuals as a cost-effective means of accessing services and activities. Public transportation tokens and transit passes may be purchased by the AE, AE contracted payment agents, Financial Management Service Organizations, or providers of service. Tokens/passes that are purchased for an individual may be provided to the individual on a daily, weekly or monthly basis.</i></p> <p>3. <i>Transportation – Per Diem. This is transportation provided to an individual by provider agencies for non-emergency purposes. This service is designed to provide individuals with access to services and resources specified in their ISP.</i></p> <p>4. <i>Transportation – Trip. Transportation provided to individuals (excluding transportation included in the rate for habilitation services) for which costs are determined on a per trip basis. A trip is either transportation to a service</i></p>	<p><i>required (or legal employer's responsibility under VF/EA and AWC models) to track mileage, allocate a portion to each participant and provide that information to the Supports Coordinator for inclusion in the participant's ISP. This will be monitored through routine provider monitoring activities.</i></p> <p>2. <i>Public Transportation. Public transportation services are provided to or purchased for participants to enable them to gain access to services and resources specified in their ISPs. The utilization of public transportation promotes self-determination and is made available to participants as a cost-effective means of accessing services and activities. Public transportation tokens and transit passes may be purchased by an OHCDs or Financial Management Service Organizations when the public transportation vendor does not elect to enroll directly with ODP. Tokens/passes that are purchased for an participant may be provided to the participant on a daily, weekly or monthly basis.</i></p> <p>3. <i>Transportation – Trip. This service is transportation provided to participants for which costs are determined on a per trip basis. A trip is either transportation to a service from an participant's private home or from the service to the participant's home. Taking a participant to a service and returning the participant to his/her home is considered two trips or two units of service. Zones are defined by ODP through the use of zones. as follows: Zone 1 – greater than 0 and up to 20 miles; Zone 2 – between 21 and 40 miles; and Zone 3 – between 41 and 60</i></p>			

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		<p><i>from an individual's home or from the service to the individual's home. Taking an individual to a service and returning the individual to his/her home is considered two trips or two units of service.</i></p> <p><i>During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. This service may be provided on an ongoing basis by qualified providers based in Pennsylvania and states contiguous to Pennsylvania. This includes individual providers that are residents of Pennsylvania or residents of states contiguous to Pennsylvania.</i></p>	<p><i>miles. Providers that transport more than 6 participants are required to have an aide on the vehicle. If a provider transports 6 or fewer participants, the provider has the discretion to determine if an aide is required. The determination must be based upon the needs of the participants, the provider's ability to ensure the health and welfare of participants and consistent with ODP requirements for safe transportation. Transportation providers may be subject to additional ODP criteria.</i></p> <p><i>During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. This service may be provided on an ongoing basis by qualified providers based in Pennsylvania and states contiguous to Pennsylvania. This includes individual providers that are residents of Pennsylvania or residents of states contiguous to Pennsylvania.</i></p>			
34	Appendix C-2.c.i Services in Facilities Subject to §1616 (e) of the Social Security Act	Prior waiver did not include 6500 in C-2-c.	Add 6500 Family Living Homes to those settings subject to the Keys amendment, and to whom ODP will require home and community based characteristics.			
35	Appendix C-2 Facility Specifications	Allow 3800, 5310 and 6400 facilities to serve 10 people if established prior to 01/01/1996.	Reduce the allowable capacity of 6400, 3800 and 5310 facilities to 8 or up to approved program capacity, whichever is less.	Given that the inclusion of people with disabilities is best accomplished when they are supported to live and work in communities with their neighbors, we request that the current residential size limitation of four people be maintained.	ACHIEVA	1.12.2012
36	Appendix C-4.a Additional Limits on	The P/FDS waiver imposes a per participant cap of \$26,000, each fiscal year, on services provided	Increase the P/FDS cap to \$30,000 per participant, per fiscal year (excluding supports coordination).	The increase of the PFDS cap to \$30,000 is an extremely positive change. We urge	ACHIEVA	1.12.2012

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	Amount of Waiver Services	(excluding supports coordination).		ODP to consider caps of \$40,000 for individuals who with companion and habilitation services could live outside the family homes, thereby decreasing the number of people on the waiting list for residential services. Only people using the waiver to live outside the family home would be eligible for the \$40,000 cap.		
37	Appendix C Quality Improvement: Qualified Providers	Describes the State's QIS to ensure that providers meet all applicable qualifications prior to providing services.	<p>The QIS has been extensively rewritten. The following are the revised performance measures. The QIS in its entirety is included in Attachment A.</p> <ul style="list-style-type: none"> • Number and percent of new providers that meet required licensure and/or certification standards and adhere to other state standards prior to furnishing waiver services. Percent = number of new providers that meet required licensure and/or certification standards and adhere to other state standards prior to furnishing waiver services/all new providers that require licensure and/or certification. • Number and percent of current providers that continue to meet required licensure and/or certification standards and adhere to other state standards. Percent = number of current providers that continue to meet required licensure and/or certification standards and adhere to other state standards /all providers that require licensure and/or certification. • Number and percent of new non-licensed, non-certified providers that meet initial waiver requirements. Percent = number of new non-licensed, non-certified providers that meet initial waiver requirements/all new non-licensed, non-certified providers. • Number and percent of current non-licensed, non-certified providers that continue to meet waiver requirements. Percent = number of current non-licensed, non-certified providers that continue to meet waiver requirements /all current non-licensed, non-certified providers. 	In the event that 100% is not achieved on a performance measure, the reason needs to be documented.	ACHIEVA	1.12.2012

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			<ul style="list-style-type: none"> • Number and percent of providers delivering services to individuals who are self-directing that meet initial requirements. Percent = number of providers delivering services to individuals who are self-directing that meet initial requirements/all providers delivering services to individuals who are self-directing. • Number and percent of providers delivering services to individuals who are self-directing that continue to meet requirements. Percent = number of providers delivering services to individuals who are self-directing that continue to meet requirements/all current providers delivering services to individuals who are self-directing. • Number and percent of licensed providers that meet training requirements in accordance with state requirements in the approved waiver. Percent = number of licensed providers that meet training requirements in accordance with state requirements in the approved waiver/all licensed providers. • Number and percent of non-licensed providers that meet training requirements in accordance with state requirements in the approved waiver. Percent = number of non-licensed providers that meet training requirements in accordance with state requirements in the approved waiver/all non-licensed providers. 			
Appendix D: Participant Centered Planning						
38	Appendix D-1.b Service Plan Safeguards	Allows Supports Coordinators that have responsibility for service plan development to provide direct services.	Revise language to clearly reflect that Supports Coordination Organization do not provide other direct services.			
39	Appendix D-1.c Supporting the Participant in Service Plan Development	Describes the process to provide information to individuals and their families in the planning process and the supports provided.	Clarify the supports and information provided to individuals and their caregivers (including the DPW website, an annotated ISP and communication assistance) and that this information is information is made available at the beginning of the process.			
40	Appendix D-1.d Service Plan	Describes the service plan development process, who is involved in developing the ISP, the	Clarify the service plan development process: <ul style="list-style-type: none"> • Note that the SIS is the standard tool used for 	The results of the SIS and all other assessments, such as behavioral or	ACHIEVA	1.12.2012

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	Development Process	assessment process, who and when the ISP is updated.	assessment of need. <ul style="list-style-type: none"> • Specify that, where applicable, an individual must have a SIS assessment completed prior to receipt of services. • Provide additional information regarding the SCO monitoring process to ensure that the ISP is developed timely, per requirements. 	therapeutic assessments, must be made available to all members of the ISP team well in advance of the ISP meeting to allow for careful review.		
41	Appendix D-1.e Risk Assessment and Mitigation	Describes the assessment and risk mitigation process with emphasis on the ISP health and safety focus area.	<ul style="list-style-type: none"> • Provide for a slightly modified risk assessment and risk mitigation process where, in addition to using the health and safety focus area of the ISP, the ISP team also develops strategies to identify, reduce and address identified risks and documents the risk in the ISP. • Identify additional tools to use for the risk assessment and risk mitigation process including relevant information from the Independent Monitoring for Quality (IM4Q), AEOMP, complaint resolution, and other feedback obtained during the annual ISP review process. 			
42	Appendix D-2.a Service Plan Implementation and Monitoring	Describes the ISP implementation and monitoring process.	Clarify the role of the SCO, AEs and ODP in monitoring the ISP and service delivery.			
43	Appendix D Quality Improvement: Service Plan	Describes the State's QIS to ensure that services plans are developed and updated in a timely manner and address all identified needs.	The QIS has been extensively rewritten. The following are the revised performance measures. The QIS in its entirety is included in Attachment A. <ul style="list-style-type: none"> • Number and percent of waiver participants who have all assessed needs addressed in the ISP through waiver funded services or other funding sources or natural supports. Percent = number of waiver participants who have all assessed needs addressed in the ISP through waiver funded services or other funding sources or natural supports/number of waiver participants reviewed. • Number and percent of waiver participants who have had a risk assessment and services and supports in the ISP to mitigate the risk where appropriate. Percent = number of waiver participants who have 	In the event that 100% is not achieved on a performance measure, the reason needs to be documented.	ACHIEVA	1.12.2012

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			<p>had a risk assessment and services and supports in the ISP to mitigate the risk where appropriate/number of waiver participants reviewed.</p> <ul style="list-style-type: none"> • Number and percent of waiver participants whose ISPs reflect their personal goals. Percent = number of waiver participants whose ISPs reflect their personal goals/number of waiver participants reviewed. • Number and percent of ISPs that are developed consistent with state policies and procedures as described in the approved waiver. Percent = number of ISPs that are developed consistent with state policies and procedures as described in the approved waiver/number of waiver participants reviewed. • Number and percent of waiver participants whose Annual ISPs were reviewed and/or revised and approved within 365 days of the prior Annual ISP. Percent = number of waiver participants whose Annual ISPs were reviewed and/or revised and approved within 365 days of the prior Annual ISP/number of waiver participants reviewed. • Number and percent of waiver participants whose needs changed and whose ISPs were reviewed/revised accordingly. Percent = number of waiver participants whose needs changed and whose ISPs were reviewed/revised accordingly/number of waiver participants whose needs changed. • Number and percent of ISPs in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the ISP. Percent = number of ISPs in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the ISP/number of participants reviewed. • Number and percent of new enrollees who are afforded choice between waiver services and institutional care. Percent = number of new enrollees 			

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			<p>who are afforded choice between waiver services and institutional care (Service Preference Choice or Form 457 Effective Begin Date on or Before Waiver Begin Date)/all new enrollees.</p> <ul style="list-style-type: none"> • Number and percent of waiver participants whose records document choice between and among services was offered to the individual/family. Percent = number of waiver participants whose records document choice between and among services was offered to the individual/family/number of waiver participants reviewed. • Number and percent of waiver participants whose records document choice between and among providers was offered to the individual/family. Percent = number of waiver participants whose records document choice between and among providers was offered to the individual/family/number of waiver participants reviewed. • Number and percent of new waiver enrollees and waiver participants who are provided information on participant-directed services. Percent = number of new waiver enrollees and waiver participants who are provided information on participant-directed services/number of new waiver enrollees and waiver participants reviewed. 			
Appendix E: Participant Direction of Service						
44	Appendix E-1.a Description of Participant Direction	Describes who can self-direct their care. States that all participants who reside in a private residence can participate in self-direction.	<ul style="list-style-type: none"> • Clarify that individuals who live in agency owned, leased/rented or operated (i.e., licensed and unlicensed Family Living homes) homes cannot self-direct their care. • Clarify that self-direction allows individuals to manage their services and initiate shifting units and associated funds between authorized participant directed services by requesting an adjustment in their participant directed services through their support coordinator to accommodate changes in need. 			

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45	Appendix E-1.e Information Furnished to Participant	States that ODP has developed and requires distribution of standard participant directed information.	<ul style="list-style-type: none"> Clarify that the standard participant direction information includes the rights and responsibilities, the benefits and any risks or liabilities associated with each participant directed option. 			
46	Appendix E-1.f Participant Direction by a Representative	Specifies that participants have the right to have a surrogate.	<ul style="list-style-type: none"> Add language to clarify that participants have the right to have a surrogate to perform the employer or managing employer responsibilities. The FMS is responsible to ensure that the selected surrogate agrees to fulfill the responsibilities of the employer or managing employer by ensuring the review and completion of the applicable ODP standard agreement form. Add language noting that the AWC FMS and the VF/EA FMS provider is required to address and report any issues identified with the surrogate's performance including compliance to the ODP policy on incident reporting and report any incident of suspected fraud or abuse. 			
47	Appendix E-1.i.i Types of Entities	Describes the types of entities that can provide FMS but does not address methods to ensure continuity of care between transition and between FMS providers.	<p>Describe protections in place to ensure health and welfare during transition between AWC FMS providers.</p> <ul style="list-style-type: none"> Should an AWC FMS provider decide to no longer provide AWC FMS administrative services, the AWC FMS shall provide ODP with at least 30 days written notice. Upon notification ODP will implement the ODP process to secure an alternative AWC FMS provider for the participant and the associated AE(s) affected. During a transition period from one FMS to another FMS, the FMS providers the SC, SCO, AE and ODP work together to ensure a smooth transition to the new FMS provider and to ensure services are delivered in accordance with the participant's ISP. 	We urge ODP to formulate a policy to protect all waiver participants from terminations by providers. The policy should include the following requirements: at least a 30 day timeframe from written notification to actual termination, the reason for the termination stated in the written notification, pendency to ensure the provider serves the person until a new provider begins to provide services and provides requested information during the transition.	ACHIEVA	1.12.2012
48	Appendix E-1.i.ii Payment for FMS	Specifies how FMS entities are compensated.	<p>Provide additional details regarding payment for FMS entities:</p> <ul style="list-style-type: none"> ODP has developed a standard methodology for reimbursing FSM administrative activities and the administrative payments to the FMS provider are separated from the service cost. AWC FMS providers receive a monthly per 			

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			<p>participant administrative fee. The monthly administrative fee is established by ODP and the AWC FMS provider and must be applied consistently with each participant within the AWC FMS provider.</p> <ul style="list-style-type: none"> • Add language regarding payment for a one-time, per participant administrative transition fee allowable only during the transition from one statewide Vendor Fiscal/Employer Agent Financial Management Service (VE/EA FMS) organization to a newly selected VE/EA FMS. 			
49	Appendix E-1.i.iv Oversight of FMS Entities	States that ODP monitors claims submitted by the FSM.	<p>Modify the description to state that:</p> <ul style="list-style-type: none"> • ODP monitors claims submitted by the AWC FMS and VF/EA FMS. Through the ODP established claims oversight methods. ODP has safeguards to ensure the payments to the FMS providers for both administrative fees and services are in accordance with all applicable regulations and requirements and maintain a consistent ratio of services to the FMS administrative costs for the individuals served. 			
50	Appendix E-1.j Information and Assistance in Support of Participant Direction	States that SCOs must provide participants with the ODP developed or approved information regarding self-direction.	<ul style="list-style-type: none"> • Clarify that the SCOs must provide participants with the ODP developed or approved information and materials regarding self-direction: during the planning process, at the annual ISP review meetings and anytime upon request. • Clarify that SCOs also provide participants with support and assistance to make the decision to exercise self-direction and refer participants to other resources. • Participants have the option to receive Supports Broker Services to assist them with their employer or managing employer responsibilities. • Participants who utilize AWC FMS may also receive assistance with the managing employer responsibilities from the AWC FMS provider. • Participants who utilize the VF/EA FMS may receive some employer assistance from the statewide VF/EA FMS and when additional support is needed the individual may elect to receive Support Broker services. 			

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51	Appendix E-1.n Goals for Participant Direction	<p>Reflects expected goals, per waiver year, regarding the number of persons selecting participant direction.</p> <p>Consolidated Waiver Year 1: 1200 Year 2: 1200 Year 3: 1200 Year 4: 1200 Year 5: 1200</p> <p>P/FDS Waiver Year 1: 1200 Year 2: 1200 Year 3: 1500 Year 4: 1500 Year 5: 1500</p>	<p>Update projections regarding number of persons selecting participant direction, per waiver year, to reflect current practice:</p> <p>Consolidated Waiver Year 1: 1000 Year 2: 1000 Year 3: 1000 Year 4: 1050 Year 5: 1050</p> <p>P/FDS Waiver Year 1: 2000 Year 2: 2000 Year 3: 2000 Year 4: 2100 Year 5: 2100</p>	<p>Irrespective of current practice, we urge ODP to not decrease the number of waiver participants engaged in participant direction in the consolidated waiver. With more information made available to participants and families, more people may choose this option.</p>	ACHIEVA	1.12.2012
Appendix F: Participant Rights						
52	Appendix F-1 Opportunity to Request a Fair Hearing	<ul style="list-style-type: none"> • Describes the procedures for offering opportunity to request a fair hearing. • Requires that AEs send a written notice to the participant or surrogate for the following reasons: <ul style="list-style-type: none"> – The individual is determined likely to require an Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care and is provided information about Waiver-funded services. – The individual who is determined likely to meet an ICF/MR level of care and is enrolled in Medical Assistance or surrogate is asked to sign the service delivery preference form (DP 457). – A decision or an action is taken that affects the individual's claim for eligibility or receipt of services. This applies to the individual's annual planning meeting as well as to any 	<ul style="list-style-type: none"> • Clarify that individual is notified of due process and appeal rights at least annually during the ISP annual review meeting and at any time the participant requests to change services or add new services. • States that standard forms will be used by the AE and ODP to issue due process and appeal rights. • Add the following language regarding the types of assistance provided by the AE, ODP and SCs shall provide: It is the responsibility of the AE, ODP and in some cases the supports coordinator to provide any assistance the individual or participant needs in requesting a hearing. This may include the following: <ul style="list-style-type: none"> – Clearly explaining the basis for questioned decisions or actions. – Explaining the rights and fair hearing proceedings of the individual or participant. – Providing the necessary forms and explaining to the individual or participant how to file his or her appeal and, if necessary, how to fill out the 	<p>The list of actions that require a written notice should be retained to ensure that people have the information necessary to make decisions and exercise their due process rights.</p>	ACHIEVA	1.12.2012

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		<p>meeting or time that services are discussed with the individual or surrogate. This would also be the basis for appeal if the application for services is not processed within the Department's established timelines.</p> <ul style="list-style-type: none"> - A decision or an action is taken to deny the individual a Waiver-funded service or to deny a willing and qualified provider of the individual's choice. - A decision or an action is taken to deny, suspend, reduce, or terminate a Waiver-funded service that is authorized on the individual's ISP. A delay of services to an individual based on the availability of Waiver funds or on a waiting list situation may be appealed on this basis. - The individual or surrogate notifies the AE or County Program of the decision to file an appeal or requests information about the individual's appeal and fair hearing rights under the Waiver. 	<p>forms.</p> <ul style="list-style-type: none"> - Advising the individual or participant that he or she may be represented by an attorney, relative, friend or other spokesman and explaining that he may contact his local bar association to locate the legal services available in the county. • Remove the list of items for which AE sends a written notice and revise the language as follows: In situations where services are denied without first being authorized in the ISP or for actions taken regarding waiver service delivery preference, the individual or participant is provided 30 days from the written notice mailing date to appeal the decision. • Add language regarding an individual's right to request an optional pre-hearing conference with the AE. 			
53	Appendix F-2.b Description of Additional Dispute Resolution Process	Describes additional resources made available to individuals outside of the appeal process to facilitate receipt of care and fair treatment, such as support provided by SC to assist in filling an appeal.	<ul style="list-style-type: none"> • Expand beyond the description of available resources to include an optional pre-hearing conference with the AE or ODP. • Add language regarding ODP monitoring of fair hearings by conducting service reviews to ensure AE compliance with regulations, approved waivers, the State plan and applicable bulletins. 			
Appendix G: Participant Safeguards						
54	Appendix G Participant Safeguards	Describes the processes the State has in place to protect the health and welfare of waiver participants as it relates specifically to the use of restraints and seclusions, incident management monitoring and medication management. The current language is found in Attachment B.	Appendix rewritten to better reflect current practice, as defined in ODP Incident Management Bulletin (#6000 04 01) and 55 PA Code §2380, §6400 and §6500. The revised language is found in Attachment C.	The following ways of uncovering and investigating unreported incidents need to be added: provider monitoring, licensing, reports made to the ODP Customer Service Line, IM4Q and reports made by disability advocacy and other community organizations.	ACHIEVA	1.12.2012

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				<p>We urge ODP to more fully clarify if, when and in which settings waivers can be granted to allow any restraints on a temporary basis .</p> <p>We urge ODP to clarify if and when certain mechanical restraints, such as helmets and mitts, can be used by people with seizures and physical disabilities to ensure their safety and welfare if no other method can provide them with the necessary protection.</p>	<p>ACHIEVA</p> <p>ACHIEVA</p>	<p>1.12.2012</p> <p>1.12.2012</p>
55	Appendix G Quality Improvement: Health and Welfare	Describes the State's QIS to ensure that services plans are developed and updated in a timely manner and address all identified needs.	<p>The QIS has been extensively rewritten. The following are the revised performance measures. The QIS in its entirety is included in Attachment A.</p> <ul style="list-style-type: none"> • Number and percent of critical incidents in which prompt action (demonstrated within 24 hours) is taken to protect the individual's health, safety and rights. Percent = number of critical incidents in which prompt action is taken to protect the individual's health, safety and rights/number of critical incidents. • Number and percent of incidents reviewed by the AE within 24 hours of the report. Percent = number of incidents reviewed by the AE within 24 hours of the report/number of incidents. • Number and percent of critical incidents finalized within the required time frame. Percent = number of critical incidents finalized within the required time frame/all critical incidents, by type of incident. • Number and percent of investigations completed by Administrative Entities (AEs) in accordance with ODP standards. Percent = number of investigations completed by AEs in accordance with ODP standards/number of investigations completed by AEs. • Number and percent of critical incidents, confirmed, by type. Percent = number of critical incidents, confirmed, by type/all critical incidents confirmed. • Number and percent of critical incidents, confirmed, 	<p>In the event that 100% is not achieved on a performance measure, the reason needs to be documented.</p>	ACHIEVA	1.12.2012

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			<p>where corrective actions were carried out or planned by the appropriate entity within the required time frame. Percent = number of critical incidents, confirmed, where corrective actions were carried out or planned by the appropriate entity within the required time frame/number of critical incidents, confirmed, where corrective actions were required.</p> <ul style="list-style-type: none"> • Number and percent of waiver participants who received information about reporting abuse, neglect, and exploitation. Percent = number of waiver participants who received information about reporting abuse, neglect, and exploitation/number of waiver participants in the sample. • Number and percent of AEs that maintain documentation of incident management training. Percent = number of AEs that maintain documentation of incident management training/number of AEs. • Number and percent of waiver participants for whom there was an unreported critical incident (i.e., ANE, serious injury of unknown cause, death of unexplained or suspicious cause), noted in the primary record and/or the service notes, by type. Percent = number of waiver participants discovered to have an unreported incident, noted in the primary record and/or the service notes, by type of incident/number of waiver participants in the sample. • Number and percent of deaths, by cause of death. Percent = number of deaths, by cause of death/all deaths. • Number and percent of deaths of waiver participants examined according to State protocols. Percent = number of deaths of waiver participants examined according to State protocols/number of deaths of waiver participants requiring examination according to State protocols. • Number and percent of incidents of restraint where proper procedures were followed, by type of restraint. Percent = number of incidents of restraint 			

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			<p>where proper procedures were followed, by type of restraint/number of incidents of restraint, by type of restraint.</p> <ul style="list-style-type: none"> • Number and percent of medication errors, by type. Percent = number of medication errors, by type/all medication errors. • Number and percent of complaints, by type. • Number and percent of complaints resolved within 21 days of receipt. Percent = number of complaints resolved within 21 days of receipt/number of complaints received. • Number and percent of providers that ensure waiver participants receive physical exams in accordance with ODP rules. Percent = number of providers that ensure waiver participants receive physical exams in accordance with ODP rules/number of providers reviewed. 			
Appendix H: Quality Improvement Strategy						
56	Appendix H-1.a.i Systems Improvement	<p>Describes the State's overall process for discovering and remediation waiver issues and implementing systems improvements, including:</p> <ul style="list-style-type: none"> • Specifies the Independent Monitoring for Quality (IM4Q) (a statewide method that PA has adopted to independently review quality of life issues for people in the D system) as a tool for identifying, tracking and trending participant waiver issues. Requires annual survey of a sample of waiver participants for IM4Q. • ODP intends to develop and publish an annual Quality Management (QM) Report to provide information on the review and analysis of stat 	<p>Revise approach to quality improvement to provide ODP with strong and reliable information on program operation and the individuals served. Recommended changes include:</p> <ul style="list-style-type: none"> • Maintain IMQ4 as part of monitoring of waiver participant quality of life but remove requirement of annual survey of waiver recipients. • Delete obligation for annual QM report but clarify that ODP uses all information gathered from the AEOM process and other monitoring and oversight activities to identify areas needing clarification or improvement and, as necessary, provide information and technical assistance. • Delete requirement for AE QM plans. 			

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		<p>ewidedataandperformanceandidentifyprioritiesfor improvements.</p> <ul style="list-style-type: none"> Requires AEs to develop and implement an Annual QM Plan that incorporates ODP's priorities and prioritizes the AE's opportunities for improvement related to compliance with waiver assurances. 				
Appendix I: Financial Accountability						
57	Appendix I-1 Financial Integrity and Accountability	Financial Integrity section describes the requirements for audits and related oversight.	<p>Made numerous proposed clarifications in this section as follows:</p> <p>Added language "as well as Title 45, CFR 92. As outlined in the waiver cost report instructions, all subrecipients receiving \$500,000 or more in combined State/Federal Funding (for profit and non-profit) need to have an annual audit conducted in accordance with Generally Accepted Governmental Auditing Standards (GAGAS)."</p> <p>"Providers are audited exclusively by contracting with CPA firms. Providers may also be selected for a GAGAS performance audit by the Department's Bureau of Financial Operations."</p>			
58	Appendix I-2.a Rate Determination Methods	Current version of the waiver contains significant detail regarding operational details of all currently utilized rate determination methodologies. Proposed revision includes all salient information, and references regulations and bulletins where operational detail is contained.	<p>There are several approaches to set rates under the PPS, depending on the type of service: fee schedule rates, cost-based rates, outcome-based payment for goods and services, and participant-directed service rates, as defined in regulation. For purposes of this waiver program, outcomes based refers to payment for the completion of a task or delivery of an item.</p> <p>Medical Assistance Fee Schedule: Select services for placement on the fee schedule are identified by ODP prior to July 1 of each year.</p> <p>Medical Assistance Fee Schedule rates are developed using a market-based approach. This process includes a review of the service definitions and a determination of</p>			

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			<p>allowable cost components which reflect costs that are reasonable, necessary and related to the delivery of the service. In developing rates for each of the MA fee schedule services, the following occurs:</p> <p>ODP evaluates various independent data sources such as a Pennsylvania-specific compensation study and data from prior approved cost reports, as applicable, and considers the expected expenses for the delivery of the services under the waivers for the major allowable cost categories listed below:</p> <ul style="list-style-type: none"> • Wages for staff • Employee-related expenses • Productivity • Program Indirect expenses • Administration-related expenses <p>One MA fee schedule rate is developed for each service and is adjusted by geographical area factors to reflect consideration for differences in wages observed across the Commonwealth.</p> <p>The fee schedule rates are established by the Department to fund the fee schedule services at a level sufficient to ensure access, encourage provider participation and promote provider choice, while at the same time ensuring cost effectiveness and fiscal accountability.</p> <p>RatesforthefollowingservicesorcomponentsofaserviceareontheMedicalAssistancefeescheduleeffective July1,2012: BehavioralSupport,Homemaker/Chore, PhysicalTherapy,OccupationalTherapy, BehaviorTherapy,Speech/LanguageTherapy,Visual/MobilityTherapy,Nursing,Companion,OlderAdult,Supports BrokerandResidentialenhancedstaffing(SupplementalHabilitationandAdditionalIndividualizedStaffing) Unlicensed</p>			

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			<p>Home and Community Habilitation, licensed Day Habilitation Services, Adult training facilities, prevocational services, supported employment, respite, transitional work, Homemaker/Chore (usual or customary fees or fee schedule will apply, whichever is less) and Support Coordination .</p> <p>Changes to the fee schedule rates and addition of services to the fee schedule are communicated through a public notice published in the Pennsylvania Bulletin prior to the effective date of any change.</p> <p>Cost-Based: The cost-based rates are developed as follows:</p> <ul style="list-style-type: none"> • Cost and utilization data is collected annually using a standardized cost report as prepared and submitted by providers of service. Cost reports undergo a desk review in which the reported data is analyzed by ODP. Reports designed for completeness and accuracy based on cost report instructions and standardized review procedures. • Cost report data is adjusted to reflect changes in the service definitions, if necessary, to account for differences in service definitions between the historical reporting period and the period in which the rates will be in effect. • Providers who do not successfully submit a cost report are assigned rates by ODP. New providers or current providers who offer new services (defined as providers that enroll and qualify to provide a new service after the cost report process is complete for that period and have no cost history) will also be assigned a rate by ODP. • For providers whose cost reports are approved, the cost report data undergo a review conducted by ODP. The review includes identifying outliers using a standardized set of criteria for all services with sufficient data 			

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			<p>points. For outliers, ODP conducts analysis to determine whether adjustments are needed to address variation among providers' unit costs.</p> <ul style="list-style-type: none"> • For residential services, a standardized vacancy factor is applied to reflect payment to providers for a limited number of medical and therapeutic leave days. • Since the cost report data is from a historical time period, a Cost of Living Adjustment (COLA) is applied as appropriated by the General Assembly. • A rate adjustment may be applied during the rate development/assignment process. This is called a Rate Adjustment Factor (RAF). RAF is done prospectively and is based on an analysis of aggregate provider expenditures compared to the budget appropriation amount. • Prior to the effective date of the rates, the methodology for calculating rates, including a description of the outlier review and rate assignment processes are communicated to the provider in the provider rate notice and in a public notice published in the Pennsylvania Bulletin. • The individual provider rate notice includes information on the process to contact ODP on questions and concerns related to the provider rate notice. Providers have the right to appeal as outlined in 55 PA Code Chapter 41. The appeal language is included in the individual provider rate notice. • ODP has a process in place to allow for additional staffing costs above what is included in the approved cost report rate for current staffing if there is a new consumer entering the program that has above average staffing needs. 			

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			<ul style="list-style-type: none"> • Effective July 1, 2012, rates for the following services or components of a service are developed using the cost-based methodology: Unlicensed Residential Habilitation in Community Homes, Unlicensed Residential Habilitation in Family Living Homes, Child Residential Services, Community Residential Rehabilitation Services, Adult Family Living Home, Child Family Living Home, Licensed Residential Habilitation in Community Homes, and Transportation (per trip). <p>Outcome-based payment for goods and services:</p> <ul style="list-style-type: none"> • ODP reimburses outcome-based services based on the cost charged to the general public for the good or service. Services reimbursed under the outcome-based approach are: Home and Vehicle Accessibility Adaptations, Assistive Technology, Supplies, Education Support, Public Transportation and Respite Care. • Transportation Mileage is reimbursed at the established rate for Department of Public Welfare employees for business travel. <p>Participant-directed service rates: Rates for participant-directed services are established through the development of standard wage ranges (which apply to both Vendor Fiscal/Employer Agent and Agency with Choice models) and a fee schedule (Agency with Choice model).</p> <ul style="list-style-type: none"> • ODP establishes the Vendor Fiscal/Employer Agent wage ranges by evaluating various data sources, such as a Pennsylvania-specific compensation study. 			

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			<ul style="list-style-type: none"> • ODP establishes wage ranges and fee schedule for Agency with Choice rates. The AWC fee schedule rate development follows the same process as that outlined previously in this section for non-participant directed services. • Effective January 1, 2012, rates for the following services or components of a service are developed consistent with the participant-directed methodologies described above: Homemaker/Chore, Supports Broker, Companion Services, Supported Employment, Unlicensed Home & Community Habilitation, and Unlicensed Respite. • The Vendor Fiscal/Employer Agent and Agency with Choice wage ranges are issued by ODP prior to July 1 each year in a standard ODP communication. In addition, the Agency with Choice Medical Assistance fee schedule rates are communicated prior to July 1 each year through a public notice published in the Pennsylvania Bulletin. • AEs and providers are subject to the requirements of the federal Single Audit Act. Resolution of these audits is coordinated by the Department's Bureau of Financial Operations (BFO). BFO and the Pennsylvania Comptroller's Office also conduct special audits of providers and AEs, upon request from ODP. BFO is involved with financial reporting, financial policy, and audit policy of ODP. The audits are supplemented by cost report desk reviews and audits. ODP uses standard procedures for the desk review of all cost reports, and a sampling methodology for conducting audits of the cost reports. • Claims are processed through PROMISewhich is administered by the Office of Medical Assistance Progr 			

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			<p>ams (OMAP)andtheDepartment’sBureauofInformation Systems(BIS).Claimsandpaymentsaremonitored byODP andAEsthroughtheuseofPROMISEandHCSISgen eratedreports.</p> <ul style="list-style-type: none"> In the future, ODP may use a variety of mechanisms to obtain public comment on rate determination methodologies, including, but not limited to stakeholder workgroup discussions, draft documents distributed for public comment, communications and public meetings. 			
59	Appendix I-2.b Flow of Billings	Flow of billings: Effective July 1, 2009, waiver providers, including cost based and fee schedule providers, vendors, FMS providers and OHCDSP providers that sign a provider agreement or contract with ODP bill through the PROMISE system and are paid by the state Treasury. Qualified support service workers and vendors providing services through an FMS for self directing individuals and vendors paid by an Organized Health Care Delivery System provider for nonself-directing individuals do not bill directly through the PROMISE system as this is the role and responsibility of the FMS and the OHCDSP provider.	All waiver providers, including cost based and fee schedule providers, vendors, FMS providers and OHCDSP providers that sign a provider agreement or contract with ODP bill through the PROMISE system and are paid by the state Treasury. Qualified support service worker sand vendors providing services through an FMS for self directing individuals and vendors paid by an Organized Health Care Delivery System provider for nonself-directing individuals do not bill directly through the PROMISE system as this is the role and responsibility of the FMS and the OHCDSP provider.			
60	Appendix I-3.d Payment	Language described methods to have AEs divest themselves from providing direct service.	Language changed to reflect that AEs providing support coordination may not provide other waiver services.			
61	Appendix I-3.g.ii Organized Health Care Delivery Systems	Language indicated that OHCDSP entities must render at least one waiver service directly	Language changed to indicate that OHCDSP entities must render at least on Medicaid service directly.			
62	Appendix I-5.b Methods for Excluding the Cost of	Language described method for excluding room and board.	Language clarified, as follows, to affirm the exclusion of room and board costs: ODP utilizes a standardized cost-based methodology in			

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	Room and Board Furnished in Residential Settings		<p>determining rates for residential waiver services. Providers are required to use a standardized cost report and follow instructions outlined by ODP. The cost report specifically instructs providers to report waiver eligible and ineligible costs separately for residential services. Providers are required to ensure that room and board costs are not entered as part of eligible costs on the cost report. ODP uses eligible costs only from the cost report to develop the waiver eligible residential rates.</p> <p>Providers complete cost reports for the services they provide and submit them to the AE. The AE is responsible to ensure that cost reports have been completed in accordance with ODP's cost report instructions.</p>			
63	Appendix I Quality Improvement: Financial Accountability	Describes the State's QIS to ensure financial accountability and stability of the waiver program.	<p>The QIS has been extensively rewritten. The following are the revised performance measures. The QIS in its entirety is included in Attachment A.</p> <ul style="list-style-type: none"> • Number and percent of claims paid using correct reimbursement rates. Percent = number of claims paid using correct reimbursement rates/number of claims paid. • Number and percent of claims paid for participants who were eligible on the date the service was provided. Percent = number of claims paid for participants who were eligible on the date the service was provided/number of claims paid. • Number and percent of claims paid where services were consistent with those in service plans. Percent = number of claims paid where services were consistent with those in service plans/number of claims paid. • Number and percent of providers whose claims are supported by documentation that services were delivered. Percent = number of providers whose claims were supported by documentation that services were delivered/number of providers reviewed. 	In the event that 100% is not achieved on a performance measure, the reason needs to be documented.	ACHIEVA	1.12.2012

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Appendix J						
64	Appendix J Cost Neutrality Demonstration	Reflects the number of individuals s expected to be served for each year of the waiver, the associated costs for serving individuals and the methodology used to calculate costs.	Will be updated to reflect the new number of individuals projected to be served for each year of the waiver, the associated costs and the methodology used to calculate costs.			