Policy and Procedure Manual

Revised 3-1-2021

Independent Living Services

1325 Elm Avenue

Lancaster PA 17603

Independent Living Services – Mission Statement

To provide quality services in the home and community that enhance the independence and enrich the lives of seniors and individuals with disabilities

Independent Living Services - Contact Information

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Chapter One

INTRODUCTION

Independent Living Services (ILS) is an operating entity of Accessing Independence. ILS is a non-profit organization that provides home care services to individuals with disabilities and age related disabilities.

The following document represents the current Policies and Procedures for Independent Living Services business operations. These policies have also been determined to comply with all state, federal, and local regulations.

The content of this manual can be reviewed and changed at anytime by Independent Living Services. In the event of any changes, ILS will ensure that information is communicated to employees.

Home and Community-Based Waiver Services in Pennsylvania

Pennsylvania Waiver Summary

Pennsylvania currently provides home and community based services and supports through eleven Medicaid waivers and numerous other state-funded programs. The Pennsylvania waivers serve over 40,000 participants with physical and developmental disabilities, with AIDS, who are technology dependent, the elderly and those with mental retardation. HCBS Waiver programs are administered by DPW.

History of the Attendant Care Program

The Department of Public Welfare initiated a three-year Attendant Care Demonstration Program in October 1984. Deinstitutionalization and preventing institutionalization were major goals of the Attendant Care Program. A major innovation of the program is that participants have the right to direct their own services i.e., screening, interviewing, hiring, training, managing, paying, and firing attendants. The three-year demonstration program enabled the Department to define the Pennsylvania Model of Attendant Care Service based on policies that provide for a continuum of care. This service delivery model has received national recognition. These policies support the concept that, to the maximum extent possible, the assistance provided be directed by the person receiving the services and that the services be provided in a manner consistent with that participant's capacity to manage it. The Attendant Care Program exists pursuant to the Attendant Care Services Act (Act 1986-1 50, 62 P.S. **9** 3051 et seq.), also known as Act 150. Act 150 provides for basic and ancillary services that enable an eligible person to remain in his home and community rather than an institution and to carry out functions of daily living, self-care and mobility.

Act 150 requires that attendant care services be provided statewide. Attendant care service shall be available only to the extent that it is funded through annual appropriation of state and federal funds. The Act took effect July 1, 1987. By December 1987, attendant care services were available in all 67 counties.

Since the inception of the Attendant Care Program, the program was funded through state appropriations and through the Social Services Block Grant (SSBG under Title XX of the Social Security Act). On August 7, 1995, the Commonwealth implemented the Medicaid Waiver for attendant care services, which accesses federal funds under Title XIX of the Social Security Act, to provide attendant care services to Medicaid eligible participants who meet other eligibility requirements.

Effective September 17, 1996, the Commonwealth limited participation in the Act 150 Program to persons who do not meet the eligibility requirements for the Medicaid Waiver. Attendant care services under the Medicaid Waiver are identical to the services provided under the Act 150 Program. There are administrative differences between the programs to allow compliance with Title XIX requirements. Primary differences include financial and level of function requirements under Title XIX, and the Title XIX requirement to enroll all eligible and willing providers.

CHAPTER TWO

An Overview of Long Term Care in Pennsylvania

PURPOSE

This chapter provides an overview of the organization and financing structures for long term care in Pennsylvania then provides evidence of long term care systems reform efforts in and why Pennsylvania is viewed as an emerging leader in home and community based care.

Organization and Financing of Long Term Care Programs

The HCBS waiver program was established in 1981 under the Omnibus Reconciliation Act(OBRA) of the Social Security Act for the Medicaid Program. To qualify for a waiver program, an individual must meet an institutional level of care and meet state residency and financial requirements. Each state sets its own guidelines and defines the particular level of care required for a person to be nursing-home eligible, such as medical diagnosis or number of functional limitations.

Medicaid supplies the majority of public funding in the U.S. for home and community-based care. Within broad federal guidelines, states have considerable flexibility in determining who is eligible and what services to cover in their Medicaid program (US Government Accountability Office [GAO], 2002). While federal Medicaid services must address the beneficiary's needs, Medicaid HCBS waiver programs permit states to provide a wide variety of services not otherwise covered under Medicaid, including respite care and other caregiver support services such as education and training.

Beginning in 2013, Pennsylvania, Long Term Care Programs are organized under one key agency: the Department of Public Welfare (DPW). Within this agency are various offices and bureaus with accountability for long-term care services and supports to children and adults with disabilities and long-term illnesses. Services and supports range from home modifications and basic in-home assistance with activities of daily living, to residential care in nursing homes and other long-term care facilities. Below is a description of these Departments' key operational units and the home and community based programs managed by each.

The Department of Public Welfare (DPW)

The Department of Public Welfare (DPW) is organized across seven different offices:

- Office of Children, Youth and Families
- Office of Income Maintenance
- Office of Medical Assistance Programs
- Office of Mental Health and Substance Abuse Services
- Office of Developmental Programs
- Office of Long Term Living
- Office of Administration

Of these seven offices, there are three within DPW, that have primary responsibility for home and community based waiver programs: the Office of Medical Assistance Programs (OMAP), the Office of Developmental Programs (ODP) and the Office of Long Term Living (OLTL).

The Office of Medical Assistance Programs (OMAP)

The Office of Medical Assistance Programs (OMAP) administers the joint State/Federal Medical Assistance program that purchases health care for close to 1.7 million Pennsylvania residents. The MA Program is authorized under Article IV of the Public Welfare Code (62 P. S. § § 401—488) and is administered in conformity with Title XIX of the Social Security Act (42 U.S.C.A. § § 1396—1396q) and regulations issued under it. This Office is responsible for enrolling providers, processing provider claims, establishing rates and fees, contracting and monitoring of managed care organizations, and detecting and deterring provider and recipient fraud and abuse. The local county assistance offices (CAO) determine eligibility for Medical Assistance. These offices also determine eligibility for Temporary Assistance for Needy Families (TANF), food stamps, and energy assistance. Family and individual eligibility criteria for Medical Assistance include income and resources.

There are eight distinct operating units within OMAP. Two of these, the Bureau of Long Term Care Programs and the Bureau of Fee for Service Programs focus on long term care.

Bureau of Long Term Care Programs

The responsibilities of this Bureau include the development and oversight of the long term care delivery system, which includes nursing facility providers and home and community-based providers and their related services. Part of this

function is to ensure that Medical Assistance eligible individuals in need of long term care have access to needed services and that the services offered in the delivery system are used appropriately and in a manner consistent with all applicable federal and state requirements. The Bureau works closely with the Department of Health and Aging on health care planning related to Medical Assistance services, licensure, certification, and quality of services, pre-admission assessments and alternative service delivery approaches.

Bureau of Fee-for-Service Programs

The Bureau of Fee-for-Service Programs is responsible for a variety of functions related to the fee-for-service portion of the Medical Assistance Program. These include administration of several special needs programs such as the Michael Dallas Model Waiver, AIDS Waiver and Targeted Case Management, Healthy Beginnings Plus and the Special Pharmaceutical Benefits Program.

The Office of Developmental Programs

The DPW Office of Developmental Programs functions under the provisions of the Mental Health and Mental Retardation Act of 1966. This regulation provides the statutory basis for the development of community-based services for people with mental retardation. Community residential options include group homes, single apartments with a roommate, or a family living setting. In addition, people are provided supports in their home whether it is their family home or their own home. Day services, such as supported employment, training, and recreation, are provided to people who live in residential settings and at home. A wide array of services and supports are also available to families caring for a child or adult sibling with mental retardation. Services include case management, mobility training, employment training and opportunities and adult day care. Some services are available for funding under the Medicaid Home and Community Based Waiver Program. The Office of Developmental Programs operates three waivers: Consolidated Waiver, Person/Family Directed Support Waiver and Infants/ Toddlers and Families Waiver.

ODP has three bureaus to carry out its operations:

< **Bureau of DD Program Operations**
The Bureau of MR Program Operations directs the fiscal and program planning, management and oversight of all mental retardation program operations including state operated facilities, community mental retardation programs and early intervention programs.

< **Bureau of DD Program Support**
The Bureau of MR Program Support develops the state and federal funding for needed services, prepares budgets and budget revisions, county allocations, federal expenditure reports, directs the county plan process, provides fiscal management of the private ICFs/MR program and Targeted Services Management (TSM) program, manages the design maintenance and implementation of the DPW Home and Community Services Information System (HCSIS), determines and prioritizes information system needs.

< **Bureau of Quality Improvement and Policy**
The Bureau of Quality Improvement and Policy directs the quality management program for the Commonwealth's mental retardation service system, develops and publishes policies and regulations, develops applications for federal funding, evaluates the effectiveness of the mental retardation program in meeting goals and providing quality services.

The Office of Long Term Living (OLTL)

The third DPW Office responsible for home and community based programs is the Office of Long Term Living (OLTL). Comprised of the Deputy's Office, the Bureau of Home and Community Based Services, the Bureau of Individual Supports, the Bureau of Provider Supports, and Personal Care Home Licensing, OLTL operates most of the home and community-based waiver programs in the state including: Attendant Care / Act 150, COMMCARE, Aging Waiver and the Community Services Program for Persons with Physical Disabilities (CSPPPD) including the Independence and the OBRA Waivers.

OLTL RE-ORGANIZATION March 2013

In the Saturday, March 9, 2013 issue of the Pennsylvania Bulletin, a reorganization chart for the Department of Public Welfare appeared. That chart contains the new Office of Long-Term Living (OLTL) structure and can be found at:

http://www.pabulletin.com/secure/data/vol43/43-10/405.html

The chart provides a very high-level outline of the new organization. There have been some staffing changes, but the core functions of the office remain the same, although some functions have been combined or rearranged. The following is a list of OLTL's new bureaus and their directors.

Four Bureaus:

Participant Operations (formerly the Bureau of Individual Support) (717) 787-8091

Director – Ginny Rogers

- o Division of Regional Operations (currently vacant)
- o Division of Transition Planning, Sharon Wilkes, Director

Policy and Regulatory Management (formerly the Office of Policy and Strategic Planning) (717) 783-8412

Virginia Brown, Director

- o Division of Policy, Elaine Smith, Director
- o Division of Regulatory Management, Randy Sipe, Director

Finance (name remains the same) (717) 787-7796

Anne Henry, Director

- o Division of Budget Development and Operations (currently vacant)
- o Division of Rate Setting and Auditing, Grant Witmer, Director

Quality and Provider Management (formerly the Bureau of Quality Management, Metrics and Analytics and the Bureau of Provider Support) (717) 724-6546

Michael Hale, Director

- o Division of Quality Assurance (currently vacant)
- o Division of Provider and Operations Management, Sallee Rowe, Director
- o Division of Nursing Facility Field Operations, Randy Nolan, Director

In addition, OLTL has a new Acting Chief of Staff, Cheryl Martin (717) 772-1145. Cheryl will oversee the following:

Project Management Office

Pattie Utz, Director
Division of Program Development and Innovation (including the LIFE Program)

(In process of being finalized)

The Pennsylvania Department of Aging (PDA)

The Pennsylvania Department of Aging (PDA) was created in 1978 by the state legislature.
PDA acknowledges that it is one of the smaller departments of state government in terms of staff, but one of the largest in terms of budget and its impact on the lives of Pennsylvanians. The department uses federal and state dollars, but most of its budget comes from the Pennsylvania Lottery Fund.

PDA oversees many services and benefits to older Pennsylvanians - most provided through the 52 Area Agencies on Aging, created in the federal Older Americans Act and Pennsylvania's Act 70. Most of the long term care programs support occurs under the Office of Community Services and Advocacy.

ILS Executive Orientation – QA, Policy, Bulletins, Compliance and Regulations

Accessing Independence was recognized as a PA Department of Human Services Provider and Licensed by the PA Department of Health on 3/1/2011. Therefore, the calendar year begins 3/1 and ends 2/28 on an annual basis to maintain licensure and comply with annual requirements. (Example's– annual training reg. 52.21, New QM plan annually)

Below is a suggested training checklist for newly hired Accessing Independence Executive Management.

- Adult Protective Services
  - http://www.dhs.pa.gov/citizens/reportabuse/dhsadultprotectiveservices/index.htm

- MA Fraud and Abuse process
  - http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/mafraudandabusegeneralinformation/index.htm

- Bulletins -
  - Office of Long Term Living(OLTL) - http://www.dhs.pa.gov/publications/bulletinsearch/bulletinsearchresults/index.htm?po=OLTL

- Waiver Regulations –
  - OLTL - http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_040102.pdf

- Department of Health Home Care Licensure and Regulations
  - https://www.pacode.com/secure/data/028/chapter611/chap611toc.html

- QA/QM
  - Dashboard
  - Monthly Participant Survey and Follow up
  - EIMS/Incident Reports
  - Monthly Quality Management Committee Meetings
  - Monthly ILS QA Internal Audit
  - Annual Required Staff Training(OLTL) http://www.pacode.com/secure/data/055/chapter52/s52.21.html

Communication Policy

Communication; whether it's written, by phone or e-mail, with a participant or a community partner, when navigating the health care system, or in the courtroom, builds relationships and enhances advocacy success. Identify verbal and non-verbal active listening skills; outline the barriers and enhancements that make a good communicator. Internet and email policy, including HIPAA practices.

- Internet and email policy, oversight of team
- Confidentiality

CHAPTER THREE

Waiver Standards

Attendant Care Waiver amended

http://www.dhs.pa.gov/citizens/attendantcare/attendantcareact150/index.htm

Independence Waiver amended

http://www.dhs.pa.gov/citizens/alternativestonursinghomes/independencewaiver/

OBRA Waiver amended

http://www.dhs.pa.gov/citizens/alternativestonursinghomes/obrawaiver/

Aging Waiver amended

http://www.dhs.pa.gov/citizens/alternativestonursinghomes/agingwaiver/index.htm

CHAPTER FOUR

Direct Care Worker requirements/training/orientation

POLICIES AND PROCEDURES:

Refer to EMPLOYEE HANDBOOK HYPERLINK:
http://www.indlivingservices.com/employee

Staff Training Policy

In accordance with 55 PA.CODE CH. 52, all staff members of Accessing Independence shall receive annual training in the following:

- Prevention of abuse and exploitation of participants.
- Reporting critical incidents.
- Participant complaint resolution.
- Department-issued policies and procedures.
- Provider's quality management plan.
- Fraud and financial abuse prevention.

Staff Training Procedure

1) All training shall be documented to include the title of the training session, date and number of hours. This documentation shall be maintained in the individual's personnel file.

2) Training may be provided by other organizations in the community. Supervisors must approve all training prior to the event.

It is the responsibility of each staff member to obtain the required hours of training each year. Any staff person who has not acquired mandatory training in the designated time frames will face disciplinary action.

Regulations

§ 611.51. Hiring or rostering of direct care workers.

(Employee Handbook Section 1.06 CLASSIFICATIONS OF EMPLOYMENT)

(a) *Hiring or rostering prerequisites*. Prior to hiring or rostering a direct care worker, the home care agency or home care registry shall:

(1) Conduct a face-to-face interview with the individual.

(2) Obtain at least two satisfactory references for the individual. A satisfactory reference is a positive, verifiable reference, either verbal or written, from a former employer or other person not related to the individual that affirms the ability of the individual to provide home care services.

(3) Require the individual to submit a criminal history report, in accordance with § 611.52 (relating to criminal background checks), and a ChildLine verification, if applicable, in accordance with the requirements of § 611.53 (relating to child abuse clearance).

(b) *Direct care worker files*. Files for direct care workers employed or rostered must include documentation of the date of the face-to-face interview with the individual and of references obtained. Direct care worker files must also include other information as required under § 611.52, § 611.53, and if applicable, § § 611.54, 611.55 and 611.56 (relating to provisional hiring; competency requirements; and health screening).

§ 611.52. Criminal background checks.

(Employee Handbook Section: 2.18 CRIMINAL BACKGROUND CHECK)

(a) *General rule*. The home care agency or home care registry shall require each applicant for employment or referral as a direct care worker to submit a criminal history report obtained at the time of application or within 1 year immediately preceding the date of application. An applicant for employment as a member of the office staff for the home care agency or home care registry and the owner or owners of the home care agency or home care registry also are required to obtain a criminal history report in accordance with requirements contained in this section.

(b) *State Police criminal history record*. If the individual required to submit or obtain a criminal history report has been a resident of this Commonwealth for 2 years preceding the date of the request for a criminal history report, the individual shall request a State Police criminal history record.

(c) *Federal criminal history record*. If the individual required to submit or obtain a criminal history report has not been a resident of this Commonwealth for the 2 years immediately preceding the date of the the request for a criminal history report, the individual shall obtain a Federal criminal history record and a letter of determination from the Department of Aging, based on the individual's Federal criminal history record, in accordance with 6 Pa. Code § 15.144(b) (relating to procedure).

(d) *Proof of residency*. The home care agency or home care registry may request an individual required to submit or obtain a criminal history record to furnish proof of residency through submission of any one of the following documents:

(1) Motor vehicle records, such as a valid driver's license or a State-issued identification.

(2) Housing records, such as mortgage records or rent receipts.

(3) Public utility records and receipts, such as electric bills.

(4) Local tax records.

(5) A completed and signed, Federal, State or local income tax return with the applicant's name and address preprinted on it.

(6) Employment records, including records of unemployment compensation.

(e) *Prohibition*. The home care agency or home care registry may not hire, roster or retain an individual if the State Police criminal history record reveals a prohibited conviction listed in 6 Pa. Code § 15.143 (relating to facility responsibilities), or if the Department of Aging letter of determination states that the individual is not eligible for hire or roster.

(f) *Records maintained*. The home care agency or home care registry shall maintain files for direct care workers and members of the office staff which include copies of State Police criminal history records or Department of Aging letters of determination regarding Federal criminal history records. The files shall be available for Department inspection. The agency or registry shall maintain copies of the criminal history report for the agency or registry owners, which shall be available for Department inspection.

(g) *Confidentiality*. The home care agency or home care registry shall keep the information obtained from State Police criminal history records and Department of Aging letters of determination regarding Federal criminal history records confidential and use it solely to determine an applicant's eligibility to be hired, rostered or retained.

(h) *Opportunity to appeal*. If the decision not to hire, roster or retain an individual is based in whole or in part on State Police criminal history records, Department of Aging letters of determination regarding Federal criminal history records, or both, the home care agency or home care registry shall provide an affected individual with information on how to appeal to the sources of criminal history records if the individual believes the records are in error.

(i) *Exceptions*. A direct care worker who has complied with this section and who transfers to another agency or registry owned and operated by same entity is not required to obtain another criminal history report. A direct care worker employed or rostered by an entity that undergoes a change of ownership is not required to obtain another criminal history report to submit to the new owner.

(j) *Individuals currently employed or rostered*. A direct care worker and each member of the agency or registry office staff who is employed by or rostered by a home care agency or home care registry as of December 12, 2009, shall obtain and submit a State Police criminal history record or Department of Aging letter of determination, as applicable, to the home care agency or

home care registry by April 12, 2010. This subsection does not apply if the home care agency or home care registry obtained a criminal history report meeting the requirements of this subsection when the direct care worker or office staff member was hired or rostered and a copy of the report is included in the individual's file.

Cross References

This section cited in 28 Pa. Code § 611.51 (relating to hiring or rostering of direct care workers); and 28 Pa. Code § 611.54 (relating to provisional hiring).

§ 611.53. Child abuse clearance.

(Employee Handbook Section: 1.04 Conditions of Employment)

(a) *General rule*. A home care agency or home care registry that serves persons under 18 years of age shall require each applicant for employment or referral as a direct care worker, each applicant for employment as a member of the agency or registry office staff to request a ChildLine verification regarding whether the applicant is named in the Statewide Central Register as the perpetrator of a founded or indicated report of child abuse as defined in 55 Pa. Code § 3490.4 (relating to definitions).

(b) *Prohibition*. A home care agency or home care registry may not employ, roster or retain an individual where ChildLine has verified that the individual is named in the Statewide Central Register as the perpetrator of a founded or indicated report of child abuse.

(c) *Records maintained*. The files maintained by the home care agency or home care registry for each individual employed or rostered and for each member of the office staff must include copies of the ChildLine verification. The agency or registry shall maintain copies of the ChildLine verification for the agency or registry owners, which shall be available for Department inspection.

(d) *Individuals currently employed or rostered*. A person who is employed by or rostered by the home care agency or home care registry, including each member of the agency or registry office staff, as of December 12, 2009, shall obtain and submit a ChildLine verification to the home care agency or home care registry by April 12, 2010. This subsection does not apply if the home care agency or home care registry obtained a ChildLine verification when the individual was hired or rostered and a copy of the verification is included in the individual's file.

Cross References

This section cited in 28 Pa. Code § 611.51 (relating to hiring or rostering of direct care workers); and 28 Pa. Code § 611.54 (relating to provisional hiring).

§ 611.54. Provisional hiring.

(Employee Handbook Section: 2.18 Criminal background Check)

(a) *General rule*. The home care agency or home care registry may hire an applicant for employment or referral on a provisional basis, pending receipt of a criminal history report or a ChildLine verification, as applicable, if the following conditions are met:

(1) The applicant shall have applied for a criminal history report and ChildLine verification, as applicable, and provided the home care agency or home care registry with a copy of the completed request forms.

(2) The home care agency or home care registry shall have no knowledge about the applicant that would disqualify the applicant under 18 Pa.C.S. § 4911 (relating to tampering with public record information).

(3) The applicant shall swear or affirm in writing that the applicant is not disqualified from employment or referral under this chapter.

(4) The home care agency or home care registry may not assign or refer the provisionally hired applicant until that person has met the requirements of § 611.55 (relating to competency requirements).

(5) The home care agency or home care registry shall monitor the provisionally hired applicant awaiting a criminal background check through random, direct observation and consumer feedback. The results of monitoring shall be documented in the individual's file.

(6) The home care agency or home care registry shall directly supervise, or assign another direct care worker to accompany, a provisionally hired applicant awaiting a child abuse clearance who will provide home care services to a consumer less than 18 years of age.

(7) The period of provisional hire of an individual who is and has been, for a period of 2 years or more, a resident of this Commonwealth, may not exceed 30 days. The period of provisional hire of an individual who has not been a resident of this Commonwealth for 2 years or more may not exceed 90 days.

(b) *Termination*. If the information obtained from the criminal history report or ChildLine verification, or both, reveals that the individual is disqualified from employment or referral under § 611.52 (relating to criminal background checks) or under § 611.53 (relating to child abuse clearance), the individual shall be terminated by the home care agency or removed from the home care registry's roster immediately. If the individual fails to provide the ChildLine verification or criminal history report, or both, within the time period permitted for provisional hire, the individual shall be terminated by the home care agency or removed from the home care registry's roster immediately.

Cross References

This section cited in 28 Pa. Code § 611.51 (relating to hiring or rostering of direct care workers).

§ 611.55. Competency requirements.

(Employee Handbook Section: 2.16 Expectations, sub Heading: Work Behaviors)

(a) Prior to assigning or referring a direct care worker to provide services to a consumer, the home care agency or home care registry shall ensure that the direct care worker has done one of the following:

(1) Obtained a valid nurse's license in this Commonwealth.

(2) Demonstrated competency by passing a competency examination developed by the home care agency or home care registry which meets the requirements of subsections (b) and (c).

(3) Successfully completed one of the following:

(i) A training program developed by a home care agency, home care registry, or other entity which meets the requirements of subsections (b) and (c).

(ii) A home health aide training program meeting the requirements of 42 CFR 484.36 (relating to the conditions of participation; home health aide services).

(iii) The nurse aid certification and training program sponsored by the Department of Education and located at www.pde.state.pa.us.

(iv) A training program meeting the training standards imposed on the agency or registry by virtue of the agency's or registry's participation as a provider in a Medicaid Waiver or other publicly funded program providing home and community based services to qualifying consumers.

(v) Another program identified by the Department by subsequent publication in the *Pennsylvania Bulletin* or on the Department's web site.

(b) A competency examination or training program developed by an agency or registry for a direct care worker must address, at a minimum, the following subject areas:

(1) Confidentiality.

(2) Consumer control and the independent living philosophy.

(3) Instrumental activities of daily living.

(4) Recognizing changes in the consumer that need to be addressed.

(5) Basic infection control.

(6) Universal precautions.

(7) Handling of emergencies.

(8) Documentation.

(9) Recognizing and reporting abuse or neglect.

(10) Dealing with difficult behaviors.

(c) A competency examination or training program developed by an agency or registry for a direct care worker who will provide personal care must address the following additional subject areas:

(1) Bathing, shaving, grooming and dressing.

(2) Hair, skin and mouth care.

(3) Assistance with ambulation and transferring.

(4) Meal preparation and feeding.

(5) Toileting.

(6) Assistance with self-administered medications.

(d) The home care agency or home care registry shall include documentation of the direct care worker's satisfactory completion of competency requirements in the direct care worker's file. If the direct care worker has a nurse's license or other licensure or certification as a health professional, the individual's file shall include a copy of the current license or certification. Documentation of satisfactory completion of competency requirements is transferable from one home care agency or registry to another home care agency or registry, provided the break in the individual's employment or roster status does not exceed 12 months.

(e) The home care agency or home care registry also shall include documentation in the direct care worker's file that the agency or registry has reviewed the individual's competency to perform assigned duties through direct observation, testing, training, consumer feedback or other method approved by the Department or through a combination of methods. The competency review must occur at least once per year after initial competency is established, and more frequently when discipline or other sanction, including, for example, a verbal warning or suspension, is imposed because of a quality of care infraction.

(f) A direct care worker employed by a home care agency or rostered by the home care registry on December 12, 2009, shall achieve compliance with the competency requirements imposed by this chapter by December 12, 2011.

Cross References

This section cited in 28 Pa. Code § 611.51 (relating to hiring or rostering of direct care workers); and 28 Pa. Code § 611.54 (relating to provisional hiring).

§ 611.56. Health screening.

(Employee Handbook Section 7.05 IMMUNIZATION AND PPD TESTING PROGRAM)

(a) A home care agency or home care registry shall insure that each direct care worker and other office staff or contractors with direct consumer contact, prior to consumer contact, provide documentation that the individual has been screened for and is free from active mycobacterium tuberculosis. The screening shall be conducted in accordance with CDC guidelines for preventing the transmission of mycobacterium tuberculosis in health care settings. The documentation must indicate the date of the screening which may not be more than 1 year prior to the individual's start date.

(b) A home care agency or home care registry shall require each direct care worker, and other office staff or contractors with direct consumer contact, to update the documentation required under subsection (a) at least every 12 months and provide the documentation to the agency or

registry. The 12 months must run from the date of the last evaluation. The documentation required under subsection (a) shall be included in the individual's file.

(c) A direct care worker employed by a home care agency or rostered by the home care registry on December 12, 2009, shall achieve compliance with the health evaluation requirements imposed by this chapter by June 10, 2010.

Cross References

This section cited in 28 Pa. Code § 611.51 (relating to hiring or rostering of direct care workers).

Bed Bug Policy

- Scope

All Employees

- Policy

It is the policy of Accessing Independence to outline the steps that should be followed to assist the participant and staff members in identifying safety issues resulting from infestation of bed bugs.

- Procedure:

Wavier and program regulations require Direct Care Worker to complete visits at the participant's home per the authorized dates and times. The Office of Long Term Living Participant Information Material Packet states "it is the responsibility of the participant to not engage behaviors that puts you or others at risk- if you put your health and safety or the health and safety of other at risk, you may lose your services."

It is the responsibility of the participant in a bed bug contaminated residence to notify the Supports Coordinator (SC) of the concern. However, if the PCA notices signs of bed bugs while providing care, it is his/her responsibility to notify their Staffing Supervisor/Safety Mentor immediately. The Staffing Supervisor will then contact the appropriate SC of the infestation, who will provide the participant with a list of local exterminators as needed. It is the responsibility of the participant to reach out to their landlord, property manager or home owner to explore community resources available to cover the cost of bed bug treatment and extermination.

The Safety Mentor will examine the situation for a health and safety risk of both the participant and the Direct Care Staff to determine if services should be placed on hold until the situation is resolved by extermination. If the participant's home is considered a risk for the Direct Care Worker to provide services- the Staffing Supervisor will immediately notify participant that DCW services will be placed on hold until the situation is resolved. The Staffing Supervisor will

contact the SC to confirm whether completion of extermination has occurred prior to resuming services.

PCAs are expected to use universal precautions whenever in the home and community. When a PCA determines they have been in an infested home, they should not return to the AI office until contaminated clothing has been changed. The PCA is expected to contact their Staffing Supervisor immediately to inform them of the situation. The Supervisor will make the HR department aware. It is recommended to remove clothing including shoes in a neutral location such as a garage. Place contaminated articles into a bag and either discard in the trash or wash them immediately in extremely hot water. Shower immediately to ensure there are no bed bugs in your hair or on your body.

If services are not placed on hold by Safety Mentor, then the participant was deemed at risk if Direct Care Workers held all services until infestation was resolved. Direct Care workers should then take precaution while continuing to provide services until infestation is resolved. DO NOT take coat, bags, or PPE Kit into the home. DO NOT sit on cushion furniture- chose to sit on wooden furniture. Have your gloves and hand sanitizer in your pockets for proper universal precautions while in the home. The Participant will have a 2 weeks period to contact a local exterminator to resolve the issue. If participant fails to do so in this time frame, Staffing Supervisor will contact Participant and SC that services are on hold until the situation is resolved.

Safety and Mentoring

S:Job Descriptions/206 Safety Mentor – August 2018

Purpose:

To provide training and mentoring to DCWs and other staff in all aspects of personal care, to ensure a safe working environment, and to promote health and safety while enhancing the participant's independence.

Procedure:

Schedule and conduct field visits, write reports including suggested follow-up (if any) to share with ILS staffing team, and update Halo. Visits include:

- Orientation Visits - to visit a new hire while at a participant's home, typically during the first 2 weeks of employment, to ensure DCWs understanding of the Service Plan and assess any need for additional training.
- 6 Month Visits – All DCW should be visited in a consumer's home at a minimum of every 6 months. This visit is intended to supply feedback for evaluations, as well as a touch point to determine the quality of the DCW's care. It is also a time to review safety protocol
- Competency Visits – within 30 days of an Annual Evaluation.
- Referral Visits – to address a specific need, typically scheduled immediately.

Provide training in personal care skills and techniques

- Provides training and assesses competency on specifics of personal care for newly hired DCWs during their initial new hire orientation.
- Provides on-site training as needed to assure an appropriate level of competency for specific tasks in a participant's Service Plan
- Provides Annual re-competency of DCWs personal care skills

Provide supervision for ILS Registered Nurses as needed by:

- Monitoring state/county mandated visits and paperwork
- Ensure that changes in participant need/care plans are effectively communicated to staffing team
- Conduct performance reviews

Investigate complaints/reports of alleged misconduct incidents involving participants

- Conduct on-site and or field investigations to investigate alleged misconduct including but not limited to fraud and abuse, neglect, participant / DCW misconduct or any other alleged misconduct which may have a negative impact on the consumer's well-being.

Promote a safe work environment for DCWs and other staff members to reduce the incidence of work related injuries.

- Conduct on-site and/or field investigations to follow up on work related injuries or reported safety concerns Hyperlink: Safety Mentor's Role in Worker's Compensation.docx
- Serve as a member of the Safety Committee
- Share and review critical incidents with safety committee
- Promote the use of proper body mechanics and risk management techniques to all AI staff through demonstration, training, and on-going coaching where a need is identified.
- Comply with all OSHA regulations and safety requirements

Follow transportation policy in regard to scheduling and using company cars for field visits.

Glove Policy

Purpose:

To establish the protocol on when DCW's should use gloves. This policy is also to determine how DCW's are expected to obtain gloves.

Procedure:

All PCA's are to be given a PPE kit upon hire, which contains gloves. These gloves are to be kept for emergency purposes, and PCA's are expected to use their own or consumer's supply of gloves. If PCA uses their supply of emergency gloves, they may make arrangements with office staff to replenish their supply.

Gloves, along with universal precautions, are to be used with all personal care activities. This especially includes, but is not limited to activities where bodily fluids are present or there is a potential for blood (shaving, oral care, etc.). Universal Precautions is to be defined by the CDC guidelines, which can be referenced at the following link:

http://www.cdc.gov/mmwr/preview/mmwrhtml/00000039.htm

CHAPTER FIVE

Intake and Enrollment -

Service Request (Referral)

Purpose:

To establish the methods by which incoming service requests can be taken from a referral source, and what information should be collected at that time.

Procedure:

Incoming requests for service can be received by office personnel in one of three methods:

1. Telephone Inquiry
2. Email
3. Fax

Initial service requests should contain enough information so that Staffing Supervisors can determine whether or not direct care workers are available. The information gathered should contain:

1. Potential participant's name, address, and telephone number
2. If a private pay customer, how many hours they think they may need service. If there is a 3rd party funding source, then how many authorized hours are they allowed
3. Information about the environment that would impact the ability to staff. For example, if there are any pets in the home.
4. If potential participant has a 3rd party representative that assists them
5. All information gathered should then be recorded on a referral form for tracking purposes

Participant Enrollment

Purpose:

To develop a consistent process where all participants receive consistent and reliable information about how their care will be provided to them.

Procedure:

Once staffing has been arranged and Independent Living Services is able to provide services to a participant, the next step is participant enrollment.

Enrollment will require that several things take place

1. A Staffing Supervisor must schedule an appointment to meet with the participant before any services can be provided
2. During the initial appointment, participant will be provided with
    a. A welcome packet that includes all information required by the Department of Health as a condition of participation for Home Care Agencies
    b. A service plan that outlines the services that direct care workers are to provide while they are there
    c. A participant binder that remains in the home and contains pertinent information that both the direct care worker and participant will need.
3. Upon completion of the in-home assessment the Staffing Supervisor must enter the participant's information into the computer and the source of payment for the participant

Participant Service Documentation (Service Reports)

Purpose:

Service Reports are designed to record specifics about time spent with a participant. The service report serves three fundamental purposes.

1. The service report records the time the direct care worker arrived and left the participant
2. The service report indicates the tasks the direct care worker performed while caring for the participant
3. The service report requires participant signature to confirm that the direct care worker, did in fact, arrive and leave at the recorded times and performed the indicated tasks

Procedure:

Service Reports will be completed by the DCW by, no later than, the end of the service period with a participant. The service report will reflect what activities the DCW performed during that service time.

Direct Care Worker's will be required to submit their service notes to the office every other week, in conjunction with the company's pay period.

The service notes will then be filed and maintained in the respective participant's office file for a period of, no less than, five (5) years.

Incoming Referrals

Purpose:

To determine the work flow for processing new referrals and who is responsible for following up with consumer/supports coordinator.

Procedure:

All referrals should originate through the resource center at UDS and be entered into the CTD.

1. If Referral is outside of ILS service area, resource center is responsible for following up with consumer or SC.
2. If Referral is in ILS service area, and referral is private pay, resource center is responsible for following up with consumer until enrollment process is completed.
3. If Referral is in ILS service area, and referral is not private pay, ILS staffing supervisors are responsible for contacting Supports Coordinator and consumer.

CHAPTER SIX

OPERATIONS

Rule and Regulation Compliance Policy

Accessing Independence will follow the following rules and regulations:

Medicaid Home and Community Based Services (HCBS) Waiver Program as authorized by the §1915(c) of the Social Security Act for the Attendant Care, Independence, OBRA and Commcare Waivers and Act 150.
.
55 PA. Code Chapter 52 Long Term Living Home and Community Based Services

55 PA. Code Chapter 1101 general provisions for Pennsylvania Medical Assistance

28 PA. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries).

Accessing Independence staff are trained on and are required to follow all current Pennsylvania Bulletins and directives from the Office of Long Term Living that relate to the Home and Community Based Services Programs. Staff will be trained on any new bulletins, directives and regulations as they are issued DPW and the Office of Long Term Living which apply to Personal Assistance Direct Care Provider.

§ 611.2. License required.

(a) Except as set forth in subsection (c), no entity or organization may operate, maintain, or hold itself out as operating or maintaining a home care agency or home care registry without first having obtained a license from the Department in accordance with this chapter. Each physical location of the home care agency or home care registry must be separately licensed. The Department will conduct an inspection prior to issuing an initial license or a license renewal.

(b) The license will specify whether the entity is licensed as a home care agency, a home care registry, or both, the term of the license, and any conditions or limitations imposed on the license.

(c) An entity operating a home care agency or home care registry, or both, as of December 12, 2009, may continue to operate after December 12, 2009, provided it submits an application for a license to the Department in accordance with instructions published in the *Pennsylvania Bulletin* and posted on the Department's web site by February 10, 2010. An entity that has submitted an application for licensure in accordance with the requirements of this subsection may continue to operate the home care agency or home care registry until a date that the Department may refuse the application for licensure. If the Department grants the application for licensure, the home care agency or home care registry may continue operation of the agency or registry in accordance with this chapter.

(d) The applicant shall obtain the application for a license to operate a home care agency or home care registry from the Department of Health, Division of Home Health.

(e) The applicant shall submit an application or renewal form to the Department with the fee of $100. The applicant shall submit a renewal form at least 60 days prior to the expiration date on the license. There will be no rebate, refund, or prorating of the application fee. The applicant shall complete a separate application and pay a separate application fee for each separately licensed home care agency or home care registry that it intends to operate.

(f) The applicant shall specify on its application the type of facility for which it is seeking a license.

§ 611.3. Affected home care agencies and home care registries.

(a) This chapter applies to home care agencies, home care registries and to entities that meet both definitions, profit or nonprofit, operated in this Commonwealth, as defined in this chapter. This chapter does not apply to a home health care agency, a durable medical equipment provider, a volunteer provider, or an organization or business entity designated under section 3504 of the Internal Revenue Code (26 U.S.C.A. § 3504) regarding acts to be performed by agents and either IRS revenue procedure 70-6 or IRS revenue procedure 80-4, that provides financial management services or supports coordination services, or both, to consumers of home and community-based services through Medicaid Waiver or other publicly funded programs.

(b) Existing home care agencies and home care registries which were home care agencies or home care registries prior to December 12, 2009, shall be required to meet the same standards as home care agencies and home care registries created after December 12, 2009.

§ 611.4. Requirements for home care agencies and home care registries.

(a) A current copy of this chapter shall be maintained at the home care agency or home care registry.

(b) Chapter 51 (relating to general information), applicable to all entities licensed as health care facitilies under the act, applies to home care agencies and home care registries licensed under this chapter.

(c) Home care agencies and home care registries licensed under this chapter shall comply with applicable environmental, health, sanitation and professional licensure standards which are required by Federal, State and local authorities.

(d) If there is a difference in applicable State or local standards, the standards established under State statutes apply for the purpose of compliance with this chapter.

§ 611.5. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Act—The Health Care Facilities Act (35 P. S. § § 448.101—448.904b).

ChildLine—An organizational unit of the Department of Public Welfare which operates a State-wide toll-free system for receiving reports of suspected child abuse established under 23 Pa.C.S. 6332 (relating to establishment of Statewide toll-free telephone number), refers the reports for investigation and maintains the reports in the appropriate file.

ChildLine verification—Confirmation regarding whether an applicant for employment or referral by a home care agency or home care registry is named in the Department of Public Welfare's Statewide Central Register as the perpetrator of a founded or indicated report of child abuse (as defined in 55 Pa. Code § 3490.4 (relating to definitions)).

Companionship services—Socialization, support and assistance with instrumental activities of daily living.

Consumer—An individual to whom services are provided.

Consumer control—Control and direction by the consumer in identifying, exercising choice of, and managing home care services in accordance with the consumer's needs and personal preferences.

Criminal history report—A State Police criminal history record or a Department of Aging letter of determination of eligibility for hire or roster based on a review of a Federal criminal history record.

Department—The Department of Health of the Commonwealth.

Department of Aging letter of determination—A written decision supplied by the Department of Aging regarding whether, based on the criminal history report from the Federal Bureau of Investigation, the applicant for employment by a home care agency or referral by a home care registry may be employed or rostered.

Direct care worker—The individual employed by a home care agency or referred by a home care registry to provide home care services to a consumer.

Direct consumer contact—Face-to-face interaction with the consumer in the consumer's place of residence or other independent living environment.

Financial management services—One or more of the following services:

(i) Managing payroll including Federal, State and local employment taxes for direct care workers recruited and retained by the consumer.

(ii) Processing the payment of workers' compensation, health and other insurance benefits for the direct care worker.

(iii) Assisting consumers in calculating and managing individual budgets for Medicaid Waiver and other publicly funded home and community based services.

(iv) Monitoring the consumer's spending of public funds and any underage or overage in accordance with the consumer's approved budget.

(v) Collecting, processing and maintaining time sheets for direct care workers.

(vi) Providing training to consumers related to employer-related tasks (for example, recruiting, hiring, training, managing and discharging direct care workers and managing payroll and bill paying).

Home care agency—An organization that supplies, arranges or schedules employees to provide home care services, as directed by the consumer or the consumer's representative, in the consumer's place of residence or other independent living environment for which the organization receives a fee, consideration or compensation of any kind.

Home care registry—An organization or business entity or part of an organization or business entity that supplies, arranges or refers independent contractors to provide home care services, as directed by the consumer or the consumer's representative, in the consumer's place of residence or other independent living environment for which the registry receives a fee, consideration or compensation of any kind.

Home care services—The term encompasses the following activities:

(i) Personal care.

(ii) Assistance with instrumental activities of daily living.

(iii) Companionship services.

(iv) Respite care.

(v) Specialized care.

Independent living philosophy—A system of beliefs, concepts and attitudes that emphasize self-direction, control, peer support and community integration for individuals with disabilities.

Inspection—A scheduled or unscheduled examination or assessment of a home care agency or home care registry during regular business hours, to determine compliance with requirements for licensure using one or more of the following means: inspection of records, interviews with office staff, consumers and direct care workers, and observation of the provision of services to consumers who have consented in advance to observation.

Instrumental activities of daily living—As defined in section 802a of the act (35 P. S. § 448.802a).

Nurse—A registered nurse or a licensed practical nurse.

Personal care—The term includes, but is not limited to, assistance with self-administered medications, feeding, oral, skin and mouth care, shaving, assistance with ambulation, bathing, hair care and grooming, dressing, toileting and transfer activities.

Respite care—Personal care and assistance with instrumental activities of daily living provided on a short term basis because of the absence or need for relief for those persons normally providing the services.

Roster—To place an individual on a list of individuals eligible to be referred by a home care registry to provide home care services to an individual in the individual's place of residence or

other independent living environment; or the list of individuals eligible to be referred by a home care registry to provide home care services to an individual in the individual's place of residence or other independent living environment.

Specialized care—Nonskilled services unique to the consumer's care needs that facilitate the consumer's health, safety and welfare, and ability to live independently.

Statewide central register—A register of child abuse established in the Department of Public Welfare, which consists of founded and indicated reports of child abuse.

Supports coordination services—Services to consumers of home and community-based services through Medicaid Waiver or other publicly funded programs including intake services, needs assessment, and advocacy to ensure coordination of medical, social, educational and other services and maximum consumer independence.

Document Management Process

PURPOSE

Document management focuses on the storage and organization of documents to support active work in progress, including content creation and sharing within an organization.

This policy is to implement consistency of Accessing Independence documentation and create a managed and centralized way for shared files and individual hard disk drives. This makes it easy for employees to find, share, and collaborate effectively on content and makes it consistent for AI/ILS to use the valuable business information and data in the content.

- Store, organize, and locate documents.
- Ensure the consistency of documents.
- Manage metadata for documents.
- Help protect documents from unauthorized access or use.
- Ensure consistent business processes (workflows) for how documents are handled.

POLICY

Enrollment Forms, Service Authorizations and other documentation are not to be saved over a previous document.

When a participant transfers from active status to an inactive status, Staffing Supervisor will transfer consumers file from Active Consumers to Termed Consumers within two business days.

Participant completed documents will be saved on the AI/ILS shared S drive within 48 hours of enrollment in a consistent format (examples below)

EXAMPLE(s):

COMPUTER PATH: S:\Participant files\Active Consumer (or Termed Consumer)

Service Authorization

Purpose:

The OLTL or SAMS Service Authorization implemented in January 2014 is the form which Service Coordinators (SCs) transmit information to direct service providers regarding the services and supports they are authorized to provide to individual program participants, SCs have used different formats in the past. Because it is important that direct service providers receive accurate, consistent and easy to use information about participant services, the bulletin established a uniform form and procedure to be used for this purpose.

Procedure:

AI/ILS must receive one of the two approved Service Authorization Forms including information regarding the authorized type, scope, amount, duration, and frequency of services as listed in the participant's service plan to the provider rendering the service to move forward with the enrollment of the participant.

The Bulletin and approved forms can be viewed at:
http://www.dhs.pa.gov/publications/bulletinsearch/index.htm

Documentation of Service Notes

Purpose:

To reflect, through documentation, the provision of service to participants. The notes should represent a complete picture of the service provided to each participant and reflect any changes in the status of the participant.

Procedure:

Service notes will be entered using the logging function in Halo. Service notes capture information referencing both DCWs and participants.

Notes will be entered within 24 hours or the next business day.

Service Notes are required to be entered to document the following:

- Phone contact with Service Coordinators, participants, or family members including a summary of call.
- All communication regarding service plan changes.
- Changes in scheduled day/time of service and changes in DCW, including notification to participant of the changes.
- Participant requested changes/cancellations.
- Open shifts/ cancelled shifts and log of reason for not providing service.
- Service Holds and Restarts – document notification to/from the Service Coordinator
- Participant visits
- Notes about distribution of new Service Authorization forms to consumer and caregivers.

Home Visit Notes

- Initial assessment
- Quarterly home visits / reassessment visits
- Annual field visit for DCW competency/evaluation
- Safety Mentor visits for emerging situations
- QA visits

Confidentiality of Participant Information and Records (Participant HIPAA)

File cabinets locked at the end of each work day

Recycle bins emptied

Encrypted email

HIPAA training for all staff

HIPPA - Confidentiality

Health Insurance Portability and Accountability Act Policy (HIPAA)

ACCOUNTABLE DEPARTMENT/PERSON: Executive Director/HIPAA Security Director.

Policy
Accessing Independence(AI) designated Covered Components shall maintain the security and privacy of participants private Health Information (PHI) in accordance with the requirements of the HIPAA statute and regulations with the Health Insurance Portability and Accountability Act of 1996 and subsequent federal regulations.

The Executive Director shall appoint a HIPAA Compliance Officer for oversight and compliance of internal AI staff HIPAA PHI, a HIPAA Privacy Officer responsible for departmental HIPPA policies, coordinating compliance with the HIPAA Privacy Rule and a HIPAA Security Officer responsible for coordinating compliance with Participants and Staff Electronic Protected Health Information Technology with the HIPAA Security Rule. The specific roles and responsibilities of these officers are set forth at the end of this policy and may be the same person.

The HIPAA Compliance Officer, HIPAA Privacy Officer, HIPAA Security Officer, and Primary Components may coordinate to develop supplemental procedures to implement this Policy.

Maintenance

This Policy shall be reviewed by the HIPAA Privacy Officer and the Primary Components as deemed necessary based on changes in the law and changes in technology that affect the protection of PHI. All iterations of this Policy shall be maintained for a period specified by applicable federal regulations.

Enforcement

Violations of this Policy may result in suspension or loss of the violator's use privileges with respect to AI Information Systems, and/or discipline up to and including termination of employment with AI. Additional civil, criminal and equitable remedies may apply.

Exceptions

Exceptions to this Policy must be approved by the HIPAA Security Director and relevant individuals in the Primary Components. All exceptions must be formally documented. Exceptions will be reviewed on a periodic basis for appropriateness.

Definitions
Electronic Protected Health Information ("EPHI") is defined as Individually Identifiable Health Information transmitted by electronic media or maintained in electronic media.

Refer to AI Policy: **Electronic Communication with Outside Providers (E-mail Encryption Policy)**

Health Information is defined as any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, public health authority, employer, school or university, or healthcare clearinghouse; and that is related to the past, present or future physical or mental health condition of an individual, the provision of health care of an individual, or the past, present or future payment for the provision of healthcare to an individual.

Individually Identifiable Health Information is defined as any heath information, as defined above, that identifies an individual or where there is reasonable basis to believe that the information can be used to identify an individual.
Protected Health Information ("PHI") is defined as Individually Identifiable Health Information transmitted by electronic media, maintained in electronic media or transmitted or maintained in any other form or medium.

Covered Component

Primary Components
AI Staff Health Information

Participant PHI

Support Employees
Individual employees within any part of AI (other than the Primary Components) who provide support services to any of the Primary Components and, as a part of such support services, have access to PHI.

Primary Components and Support Employees are collectively referred to as "Covered Components."

Each AI program is responsible for:

Assisting the HIPAA Privacy Officer and the HIPAA Security Officer.

Implementing policies, procedures and controls developed in collaboration with the HIPAA Privacy Officer and the HIPAA Security Officer to comply with the HIPAA Policy.

Periodically conducting a risk assessment, in collaboration with the HIPAA Privacy Officer and the HIPAA Security Officer, to measure potential risks to the security and privacy of PHI within the department.

Coordinating with the Executive Director (HIPAA Security Director) to ensure that an appropriate Business Associate Agreement is in place with a third-party, prior to conducting business that involves the handling of PHI applicable to the Primary Component. Each department liaison is responsible for maintaining copies of any Business Associate Agreements concerning the Primary Component.

Notifying the relevant Support Employees that such employees may have access to PHI as a result of working with the Primary Component.

Support Employees are responsible for:

Following any policies, procedures and controls established by the Primary Components, the HIPAA Compliance Officer, HIPAA Privacy Officer, and/or the HIPAA Security Officer regarding access to and the use of the PHI.

Cooperating with any risk assessment initiated by the Primary Components, the HIPAA Compliance Officer, the HIPAA Privacy Officer, and/or the HIPAA Security Officer.

HIPAA Compliance Officer

The HIPAA Compliance Officer is a AI employee or Management Company individual who is responsible for the development and implementation of the policies and procedures required to comply with the HIPAA Privacy Rule for AI staff PHI and AI Group Health plan as defined by the Code of Federal Regulations, 45 C.F.R. 160, 162 and 164.

The HIPAA Compliance Officer is responsible for:

Understanding the HIPAA Privacy Rule and how it applies.
Developing appropriate policies and procedures to comply with the HIPAA Privacy Rule.

Overseeing the enforcement of AI staff privacy rights within each Covered Component.

Monitoring each Covered Component for compliance with privacy policies and procedures.

Developing and implementing HIPAA privacy training for employees within each Covered Component.

Notifying the HIPAA Security Director of any Business Associate Agreements that implicate EPHI, prior to the execution or amendment of any such agreement.

Receiving and responding to complaints of alleged non-compliance with the HIPAA Privacy Rule.

The HIPAA Compliance Officer is appointed by the Executive Director.

HIPAA Privacy Officer

The HIPAA Privacy Officer is an AI employee who is responsible for the development and implementation of the departmental policies and procedures required to comply with the HIPAA Privacy Rule as defined by the Code of Federal Regulations, 45 C.F.R. 160, 162 and 164.

The HIPAA Privacy Officer is responsible for:

Understanding the HIPAA Privacy Rule and how it applies within each Covered Component.

Developing appropriate department policies and procedures to comply with the HIPAA Privacy Rule.

Overseeing the enforcement of participant privacy rights within each Covered Component.

Monitoring each Covered Component for compliance with privacy policies and procedures.

Developing and implementing HIPAA privacy training for employees within participant Covered Component.

Notifying the HIPAA Security Director of any Business Associate Agreements that implicate EPHI, prior to the execution or amendment of any such agreement.

Receiving and responding to complaints of alleged non-compliance with the HIPAA Privacy Rule.

The HIPAA Privacy Officer is appointed by the Executive Director.

HIPAA Security Officer(s)

The HIPAA Security Officer(s) is an AI employee who is responsible for coordinating compliance with the HIPAA Security Rule as defined by the Code of Federal Regulations, 45 C.F.R. 160, 162 and 164.

The HIPAA Security Officer is responsible for:

Understanding the HIPAA Security Rule and how it applies within each Covered Component.

Developing appropriate policies and procedures to comply with the HIPAA Security Rule

Overseeing the security of Electronic Protected Health Information (EPHI) within each Covered Component.

Monitoring each Covered Component for compliance with EPHI security policies and procedures.

Identifying and evaluating threats to the confidentiality and integrity of EPHI.

Responding to actual or suspected breaches in the confidentiality or integrity of EPHI.

The HIPAA Security Officer is appointed by the Executive Director.

User

For the purpose of this policy, a **User** is any AI employee or a Support Employee who is authorized to access PHI and/or access AI Information Systems that store EPHI.

A User is responsible for:

Abiding by the HIPAA Policy and supporting procedures.

Reporting actual or suspected vulnerabilities in the confidentiality or integrity of PHI and or the suspected breaches in the security or privacy of PHI to the HIPAA Compliance Officer, HIPAA Privacy Officer and/or the HIPAA Security Officer.

Reporting suspicious requests for PHI to the HIPPA Compliance Officer, HIPAA Privacy Officer and/or the HIPAA Security Officer.

Additional Information

If you have any questions or concerns related to these roles and responsibilities, please contact:

HIPAA Security Director:	AI Program Director
HIPAA Compliance Officer	Robin Ulrich, NPMS
HIPAA Privacy Officer:	Erik Lofgren, NPMS
HIPAA Security Officer:	Erik Lofgren, NPMS

After Hour On Call Policy

Purpose: Eliminate staff travel during on-call time

Current phone switch-over process: The Resource Center phone line is transferred over to the answering service at 4:45pm each evening. The Staffing line is switched over at 4:30pm, and then the Tamaqua line is also switched over to the Staffing line at 4:30pm. In the morning, the answering service is then switched off for the Staffing line at 7:30am, the Tamaqua line at 7:30am, and then the Resource center line at 8am.

Procedure: ILS will utilize on call coordinators to handle all calls after hours, on weekends, holidays and office closures. In the event that an on call coordinator is not available, this responsibility would fall on the Staffing Supervisors and Safety Mentors. In that event, the following procedures will be followed: The individual on call will remain at home between 4:30pm and 7:30am, available to take calls. This means that if you are on call, you will be leaving the office early in order to be home by 4:30p, and coming in late the next morning. To ensure important calls are not missed, every individual on call needs at least 2 voice mail messages; the standard and the out of office. Both messages must indicate 'for immediate attention, please press "0"'. Please also provide in your message the 'quick key' for your team members, in case they don't know who to select. So it sounds something like, 'for immediate attention, please press "0", and then either "3" or "4" to get someone else on my team. You also have the option of transferring your calls to someone else you know can take them.

Data Classification and Handling Policy

Overview

It is the policy of Accessing Independence (AI) to follow a system of data classification, handling, retention, and destruction in order to protect information that is critical to the organization and confidential to the consumers we serve. All workers who may come into contact with confidential information are expected to familiarize themselves with this data classification policy and use it consistently.

Policy

The organization's data classification system has been designed to support the "need to know" principle so that information will be protected from unauthorized disclosure, use, modification and deletion. Consistent use of this data classification system will facilitate business activities and help keep the costs of information security to a minimum. Without consistent use of this data classification system, AI unduly risks loss of consumer relationships, loss of public confidence, internal operational disruption, excessive costs, and competitive disadvantage.

Applicable Information: This data classification policy is applicable to all information in AI's possession. For example, medical records on consumers, confidential information from suppliers, business partners and others must be protected with this data classification policy. No distinctions between the words "data", "information", "knowledge", and "wisdom" are made for the purposes of this policy.

Consistent Protection: Information must be protected consistently throughout its lifecycle, from its origin to its destruction. Information must be protected in a manner commensurate with its sensitivity, regardless of where it resides, what form it takes, what technology was used to handle it, or what purpose(s) it serves. Although this policy provides overall guidance, to achieve consistent information protection, workers will be expected to apply and extend these concepts to fit the needs of day-to-day operations.

Classification Labels

Public: This classification applies to information that is available to the general public and intended for distribution outside the organization. This information may be freely disseminated without potential harm. Examples include product and service brochures, advertisements, job opening announcements, and press releases.

For Internal Use Only: This classification applies to all other information that does not clearly fit into the other classifications. The unauthorized disclosure, modification, or destruction of this information is not expected to seriously or adversely impact the organization, its consumers, its employees, or its business partners. Examples include the AI Agency Directory, new employee training materials, and internal policy manuals.

Confidential: This classification applies to information that is intended for use within the organization. Its unauthorized disclosure could adversely impact the organization, its consumers, its employees and its business partners. Information that some people would consider private is included in this classification. Examples include medical information (except

that which is restricted confidential), consumer medical information, appointment schedules, consumer account records, department financial data, purchasing information, vendor contracts.

Restricted Confidential: This classification applies to the most sensitive medical and business information that is intended strictly for use within the organization. Its unauthorized disclosure could seriously and adversely impact the organization, its consumers, its employees, and its business partners. Examples include statutorily protected medical information such as mental health treatment, HIV testing, sexually transmitted diseases, abortion, and alcoholism or substance abuse treatment data. Other examples are merger and acquisition documents, corporate level strategic plans, and litigation strategy memos.

Data Classification Matrix

Refer to *Appendix A: Classification Matrix* for the handling and security requirements for information based on its classification.

Appendix A: Classification Matrix

	Public	Internal Use Only	Confidential	Restricted Confidential
Examples	Product and service brochures, advertisements, job opening announcements, and press releases.	AI Agency Directory, new employee training materials, and internal policy manuals.	Medical information (except that which is restricted confidential), consumer medical information, appointment schedules, consumer account records, department financial data, purchasing information, vendor contracts.	Statutorily protected medical information such as mental health treatment, HIV testing, sexually transmitted diseases, abortion, and alcoholism or substance abuse treatment data.
Criteria	Information that is available to the general public and intended for distribution outside the organization.	All other information that does not clearly fit into the other classifications.	Information that is intended for use within the organization.	Sensitive medical and business information that is intended strictly for use within the organization.
Handling Standards	No special handling required.		Encryption is required when sending information over an untrusted network; i.e., the Internet or non-secure email system. When sensitive information is commingled with non-sensitive information through computer processing and merging of data or insertion of documents files, the resulting file, tape, or disk which contains the commingled data must be clearly labeled that "Sensitive information is Included..	
Release to Third Parties Standards	Available to the general public and for distribution outside of AI.	Intended for use only within the AI. May be shared outside AI only if there is a legitimate business need to know, and is approved by the data owner and users manager.	Access limited to as few persons as possible on a need to know basis. Information is very sensitive and closely monitored using auditing tools. Information is controlled from creation or acceptance to destruction or return of information. Release only permitted by appropriate policies and procedures.	

Transmission **by Post, Fax, E-Mail** **Standards**			a. Sealed inter-office envelope marked and labeled “sensitive Information”. Notify recipient in advance.
a. Mail within the organization (interoffice).	a. No special handling required.	a. No special handling required.	b. 1st class USPS mail. Trackable delivery required, e.g. messenger, FedEx, U.S. express, USPS certified, or return
b. Mail outside of the organization	b. No special handling required.	b. 1st class mail. No special handling required.	receipt mail.
c. E-mail within the organization	c. No special handling required.	c. No special handling required.	c. Refrain from use of customer SSAN. Use of e-mail strongly discourage unless encrypted.
d. E-mail outside of the organization	d. No special handling required.	d. No special handling required.	d. Use of customer SSAN prohibited, unless encrypted or emergency situation. Use of e-mail strongly discouraged.
e. FAX 1). Location of fax machine.	1). Located in area not accessible to general public.	1). Located in area not accessible to general public.	1). Located in area not accessible to general public and unauthorized persons.
2). Use of fax coversheet.	2). Required.	2). Required. 3). Reasonable care in dialing.	2). Required. Coversheet labeled “Sensitive Information”.
3). Transmission safeguards.	3). Reasonable care in dialing.		3). Telephone notification prior to transmission and subsequent telephone confirmation of receipt required.

Transmission by spoken words standards a. Conversation/ Meetings b. Telephone c. Cellular Telephone	No special precautions required.	Reasonable precautions to prevent inadvertent disclosure.	Active measures and close control to limit information to as few persons as possible. a. Enclosed meeting area. Public areas prohibited. b. Avoid proximity to unauthorized listeners. Speakerphone in enclosed area. Use generally discouraged. c. Use of digital telephones discouraged, landline preferred.
Print, Film, Fiche, Video Standards a. Printed Materials b. Sign-in sheets/ Sign-in Logs c. Monitors/Computer	No special precautions required.	Reasonable precautions to prevent inadvertent disclosure. a. Store out of sight of nonemployees. b. Placement out of sight of non-employees. c. Positioned or shielded to prevent viewing by nonemployees.	Active measurers and close control to limit information to as few persons as possible. a. Store out of sight in a lockable enclosure. b. Subsequent signers cannot identify signer. c. Position or shield to prevent viewing by unauthorized parties. Possible measurers include, physical location in secure area, positioning of screen, use of password screen saver, etc.
Copying Standards	No special precautions.	No special precautions.	Photocopying with approval by Data Owner. (Note: If a digital copier is used, cache needs to be erased.)

Storage Standards a. Printed Material b. Electronic documents c. E-mail	a. No special precautions required. b. Storage on all drives. c. No special precautions required.	a. Reasonable precautions to prevent access by non-employees. b. Storage on all drives. c. Reasonable precautions to prevent access by unauthorized personnel.	a. Storage in a lockable enclosure. b. Storage on secure drives only. Password protection of document preferred. Use of Object Reuse to erase sensitive information or destruction of drive. c. Encrypted storage and backup tape in a secure place or container.
Destruction Standards a. Destruction b. Location of waste paper bins. c. Paper recycling. d. Magnetic media/diskettes.	a. No special precautions required. b. No special precautions required. c. Permitted. d. No special precautions required.		a. Destroy in a manner that protects sensitive information. b. Secure area not accessible to unauthorized persons. c. Prohibited. Destruction or shredding required. d. Use object reuse to overwrite sensitive information.

Revision History

Name	Date	Reason for Changes	Version
Alec Nauck-Heisey	2/8/12	Initial draft	1.0 draft 1

Translation and Interpretation Services for a Participant Policy

(Limited English Proficiency)

BACKGROUND: Accessing Independence is committed to having its Participants understand its services and documents. However, there are some Participants whose primary language is not English and who may not clearly understand either the written or spoken word. Other Participants may need assistance due to vision or hearing loss.

PROCEDURE: As a Staffing Supervisor assess that assistance is needed with either translation or interpretation, Accessing Independence will make every effort to ensure that the Participant understands the written and/or spoken word.

If a translator or interpreter is not available, Accessing Independence will contact one of the following schools or agencies to determine if a resource is available to translate.

Services/Providers available are as follows:

- Staff from the Language Department from the following Universities:
  - Dickinson College Phone:1-717-243-5121
  - Franklin and Marshall College Phone:1-717-291-3911
  - Penn State University Global Programs Phone:1-814-865-7681
- Sign Language: TRCIL Phone: 1-800-633-4588
- All Languages: Interpreters Unlimited Phone:1-800-726-9891
- AT & T Language Line Service Phone:1-800-752-6096
- Nationalities Service Center Phone:1-215-893-8400

The Staffing supervisor will document in the Participant's file the name and relationships of those who provide assistance with translation.

The Staffing supervisor will obtain agreement from the Participant when a translator is being employed.

Children under the age of 18 will not be used as translators.

Accessing Independence will be responsible for the cost of the translator/interpreter.

Communication Process

Upon review of participant's service notes, if there is concern about a reoccurrence of denial of services, Staffing Supervisor or Safety Mentor must contact the SC as soon as possible. This concern would revolve around the safety and well-being of the consumer. An example of this could be complete refusal of PCA entry, continued refusal of hygiene or personal care, refusal to sign task sheet, etc.

Participant Termination of Services

Purpose:

To provide Accessing Independence staff with the State regulations on how to handle the following:

- Non-eligibility for services
- Reduction in services
- Termination of services

Definitions:

Reduction in Services is a decrease in the number of regularly scheduled hours of services a participant receives due to a decrease in need or the total elimination of certain services when it is determined that the participant no longer needs those particular services.

PAS providers have a right to terminate services from participants. If the PAS provider makes this choice & sends the 30 day notice to the SC & participant, the participant does not have a right to appeal. The SC would work with the participant to find another PAS provider.

The participant would only have a right to appeal if the SC made the determination to reduce or terminate services. In that case, the MA 561 is sent by the SC entity.

Conditions Under Which Services May Be Reduced or Terminated:

Should the Home and Community Based Services modification be involuntary and result in participant disagreement, AI Staff will exhaust all means to resolve issues leading to services reduction or termination.

AI staff will follow the AI Policy on Compliant and Grievance Process; it will be initiated prior to mailing a 30 Day termination letter. Thorough documentation of efforts to resolve differences and keep the participant informed will be submitted in writing to the participant's supports coordinator and will be recorded in HALO.

PAS providers need to send participant a 30 day notice when terminating services.

Professional Judgment/Just Cause

The Staffing Supervisor or Executive Director may reduce or terminate services to a participant when, in their professional judgment, one of or more of the following circumstances exist(s).

- The participant no longer needs certain services or the level of services currently being provided.
- The participant needs a level of services that is beyond the scope and purpose of the HCBS Waiver Program.
- The participant routinely exhibits uncooperative behavior, misuses services, and/or abuses his/her personal assistant and/or the AI staff.
- Unsafe or unsanitary conditions exist or unsafe activities occur in the participant's home jeopardize the health or safety of his/her personal assistant and/or AI staff.

- The participant is involved in activities perceived by any reasonable person apprised of the facts to be of an illegal nature.
- The participant signs and/or submits time sheets or uses the electronic time and attendance system for services not provided or hours not worked by an attendant with purposeful intent to defraud.
- The participant does not remit assessed fees in accordance with the payment schedule mutually agreed upon by the participant and the contractor.

When, in the AI Staffing professional judgment, a participant's services must be reduced or terminated, the participant's Supports Coordinator needs to be notified.

The AI staff must review this decision with their Supervisor prior to beginning the process of reducing/terminating services.

The participant must be notified in writing no less than 30 days prior to the effective date of service reduction or termination. A letter will be completed, mailed to the participant, and serve as official notification. The supervisor will notify the Service Coordinator.

The AI team member and Supervisor must document and share the termination process with the participants Service Coordinator.

Participant's Responsibility in Filing an Appeal

- In accordance with 55 PA Code, Chapter 275, a participant retains the right to a departmental fair hearing only if the Bureau of Hearings and Appeals receives a request for a hearing within 30 calendar days of the date on the
- As directed by instructions on the Notice, the participant's request must specify the reason(s) for the appeal and his/her current address and a daytime telephone number.
- The participant may elect to be represented at a hearing by any person of his/her choosing, including an attorney.
- The participant must submit the request for a hearing to their Supports Coordinator who will, in turn, forward to the Supervisor for submission to the Bureau of Hearings and Appeals.

AI Responsibility Related to the Appeal

- The AI Staffing Coordinator and Supervisor will inform participants Supports Coordinator at least 30 days in advance of termination of services.
- AI may not take the proposed adverse action until at least 30 calendar days have elapsed from the date the participant was notified of the intent to reduce or terminate services, except if directed by OLTL.

Service Provision during an Appeal:

- If, within 10 calendar days of the date the participant was notified of the adverse action, AI receives an appeal requesting a hearing, the existing level of services must continue until the appeal is heard and a decision is rendered by the Bureau

of Hearings and Appeals. Should services reduction and/or termination be due to the existence of unsafe or unsanitary conditions or because activities are occurring which jeopardize the health or safety of an attendant and/or the AI staff, the AI Staffing Supervisor and Executive Director needs to consult with the OLTL-BHCBS to develop a plan of action.

- OLTL-BHCBS recognizes that home and community based programming is unique in the demands placed upon services providers. That is, unlike financial assistance entitlement programming and/or many other services of the Department, the HCBS Waiver programs are "in-home" services models. Staff acting on behalf of the HCBS Waivers routinely provides service at all hours of the day or night and most often in the presence of no other persons (apart from the participant). In recognition of this fact, the Department will not knowingly require HCBS funded personnel to risk assault or other significant harm in the fulfillment of duty. The BHCBS will send an explanatory letter to the participant (with a copy to AI) should services suspension be deemed necessary. The Department will also inform Departmental Legal Counsel and other authorities, as appropriate.

Participant Power of Attorney, Legal Guardian or Representative

Purpose:

To provide Accessing Independence staff with the Policy and Procedure on how to handle a participant having a;

- Power of Attorney(POA)
- Legal Guardian(LG)
- Representative

Definitions

Legally Authorized Representative.

A legally authorized representative is an individual or body authorized under applicable law to provide permission on behalf of a prospective participant for the participant's participation in the Pennsylvania Home and Community Based Service Program for the purposes of this policy, a legally authorized representative includes a person appointed as a health care agent under a Durable Power of Attorney for Health Care (DPAHC), a court appointed guardian of the person, but also a representative that is determined by the participant's supports coordinator and indicated on the Pennsylvania HCBS Service Authorization Form.

Legal guardian. A person appointed by a court of appropriate jurisdiction.

Power of Attorney for Health Care

As its name suggests, a power of attorney for health care allows the person you designate as your agent to carry out decisions regarding health care in the event a participant cannot legally make those decisions for themselves. A power of attorney for health care often includes instructions concerning life support, burial, cremation, organ and tissue donation, and whether a person elects to have certain medical procedures performed, such as CPR and kidney dialysis.

Durability Feature

A general power of attorney gives your agent the power to act on a participant behalf as soon as they sign the document, but the agent loses that power upon the participant's incapacity. A power of attorney for health care is designed to allow someone to make decisions for participants upon their incapacity. Unlike with a traditional power of attorney, a durable power of attorney allows a participant's agent to make decisions while they are incapacitated. It is for this reason that the power of attorney for health care is referred to as "durable."

Procedure:

AI staff must review the Service Authorization to determine if there is a POA, Legal Guardian or representative indicated.

If a power of attorney or legal guardian is indicated, the AI enrollment team must acquire a copy of the Durable POA or LG document prior to the enrollment paperwork process.

Not all POA's are for health care decisions. The POA must indicate the durable power to represent the participant for health care.

When the service coordinator has indicated a POA, LG or representative on the service authorization, only the individual named may officially sign AI documentation.

If any AI team member is informed that a participant will be using a POA, LG or representative and it is not listed on the service authorization, the participant's service coordinator must be notified in writing immediately and AI must receive an updated service authorization with the POA, LG or participant's representative indicated prior to providing services or accepting signatures from a POA, LG or participants representative.

DCW Task Sheets Policy

Purpose:

To determine a process for documentation of time and activity in the event that telephony is unavailable.

Process:

In the event that a consumer or Personal Care Attendant is unable to use ILS' telephony process for accountability, the caregiver will use Task Sheets in lieu of telephony. PCA will document time in/out as well as tasks performed in accordance with tasks that are authorized by Service Authorization Form. PCA will then have consumer place signature on those sheets to verify hours and tasks are accurate. It will then be up to the PCA to submit that documentation prior to payroll Monday in order to ensure timely billing and pay.

Some examples of why telephony would not be available would be, but not limited to: Consumer does not have phone available, Consumer refuses PCA access to their phone for telephony purposes, technical error with Telephony service, etc.

Prior to submitting task sheet documentation for billing and payroll purposes, Staffing Supervisor will verify that all hours and dates are signed off on by consumer or consumer representative. If sheet is missing signature, Staffing supervisor may contact consumer to verify hours and tasks were performed according to the documentation.

CHAPTER SEVEN

Quality Management

Quality Management Program

March 1, 2016 – February 28, 2017 Quality Management Plan

S:\Quality Management

Monthly QA Participant File Monitoring Policy

Purpose: Accessing Independence (AI) is committed to providing high quality care to its participants. AI performs the following processes to ensure participant satisfaction and compliance with AI policies and procedures, as well as federal and state regulations:

Responsibilities of QM Team:

- Review of bi-monthly **Critical Events/Incidents** including follow up and quality improvement recommendations
- Review of bi-monthly **Grievances/Complaints** Report including follow up and quality improvement recommendations
- Review Quarterly Participant **Satisfaction Surveys**
- Ensure that required **training** under regulation 52.21 is provided annually
- Review of monthly **QA audit** results
- Review of open items from previous month's meeting

Critical Events/Incidents:

- With the implementation of OLTL- EIM effective October, 2011, EIM is reviewed in detail during monthly QA monitoring. Critical Events/Incidents through EIM are analyzed during the QA monthly monitoring, trends are identified, and recommendations for program improvement and prevention are discussed for implementation. Any required follow up is noted in meeting minutes for final follow up during the following AI QA meeting. OLTL-QMET completes the final EIM review, investigates, as needed and closes the report in EIM, as appropriate. Team will also review and analyze all non-OLTL incidents that are recorded in ILS internal database.

Grievances/Complaints:

- All grievances/complaints will be documented in Halo by the individual who receives the complaint and documented on complaint log. Individual will be responsible for providing resolution, documentation and communication of resolution.
- The Safety Mentors will review complaint log, prior to the QA meeting, to insure resolution has been recorded.

- Grievances/Complaints are analyzed on a monthly basis by the QA Team at the QA meetings. The reports from all offices are reviewed, trends identified, and recommendations for program improvement and prevention are discussed and implemented.

Satisfaction Surveys:

- At least 2 participants per staffing supervisor will have satisfaction surveys conducted by the resource center monthly. The sample will include newly enrolled participants within ninety (90) days of enrollment. The QM Committee will review the satisfaction report results and submit suggested improvements with the monthly summary report to the AI Program Director. Goal is to achieve a satisfaction overall score of 75% or greater.
- 10% of Schuylkill County Options consumers surveyed monthly (pg. 58 of contract)

Training:

The QM Team ensures the following required trainings are provided:

- New hire orientation
- HALO training for new hires
- Direct Care Worker Competency Training
- Annual staff member training - § 52.21
    - (d) A provider shall implement **standard annual training** for staff members providing services which contains at least the following:
    - (1) Prevention of abuse and exploitation of participants.
    - (2) Reporting critical incidents.
    - (3) Participant complaint resolution.
    - (4) Department-issued policies and procedures.
    - (5) Provider's quality management plan.
    - (6) Fraud and financial abuse prevention.

QA Audits:

- The QM team will review the prior month's audit results from the Participant File Follow up Dashboard, and establish trends, retraining needs, and identify opportunities for improved processes.
- The QM team will review and discuss the "unjustified hours" portion of the audit and discuss remedies and solutions if necessary.
- The team will also review the summarized audit results.

Quality Improvement Goals:

- Maintain a QM Team which meets regularly to analyze all critical events/incidents, grievances/complaints, participant file reviews, fraud issues, surveys, and other service delivery issues
- Maintain standardized policies, procedures, forms, and standardized shared drive across AI sites, including but not limited to SOP and Halo.
- Maintain QM monthly check list to review Participant files
- Track and trend grievance/complaints with process improvement recommendations
- Reviewing training tracking process to determine if we can create any efficiencies

Monthly QA Participant File Monitoring Checklist

Hyperlink: S:\Quality Management\ AI QA Monthly Check List 2014

QA Monitoring Check List

Participant Name:	**Date:**	**Period Reviewed:**	
QM Committee Member Name:	**Waiver:**	**QM Meeting Date:**	
Databases and Files	Completed	Needs Revised	Notes
1. Enrollment visit			
☐ Enrollment visit complete and filed			
• Welcome letter from Executive Director			
• Office of Long-Term Living Standardized Home and Community-Based Services Waiver Participant Informational Materials			
• Participant has been visited prior to services beginning			
• Notice that the Direct Care Worker has received a copy of the home care service plan to be provided to the Participant			
• Rights & Responsibilities			
• AI Consent to Release			
• Notice of Privacy Practice			
• HIPPA Consent Form			
• A listing of the available home care services that will be provided to the consumer by the direct care worker and the identity of the direct care worker who will provide the services			
• The hours when those services will be provided			
• Fees and total costs for those services on an hourly or weekly basis			
• Who to contact at the Department for information about licensure requirements for a home care agency or home care registry and for compliance information about a particular home care agency or home care registry			
• The Department's complaint Hot Line (1-866-826-3644) and the telephone number of the Ombudsman Program located with the local Area Agency			

on Aging (AAA).			
• The hiring and competency requirements applicable to direct care workers employed by the home care agency or referred by the home care registry			
• A disclosure, in a format to be published by the Department in the Pennsylvania Bulletin by February 10, 2010, addressing the employee or independent contractor status of the direct care worker providing services to the consumer, and the resultant respective tax and insurance obligations and other responsibilities of the consumer and the home care agency or home care registry has been given to the Participant and/or Participant's representative			
• AI/ILS Brochure			
• Notice that the participant receives at least 10 calendar days advance written notice of the intent of the home care agency or home care registry to terminate services. Less than 10 days advance written notice may be provided in the event the consumer has failed to pay for services, despite notice, and the consumer is more than 14 days in arrears, or if the health and welfare of the direct care worker is at risk			
• Notice that no individual has, as a result of the individual's affiliation with a home care agency or home care registry may assume power of attorney or guardianship over a consumer utilizing the services of that home care agency or home care registry. The home care agency or home care registry may not require a consumer to endorse checks over to the home care agency or home care registry			
• Information that the Participant is involved in the service planning process and receives services with reasonable accommodation of individual needs and preferences,			

except where the health and safety of the direct care worker is at			
• Enrollment checklist signed, complete and in file			
☐ Service Note entered			
2. Direct Care Worker Task Sheets			
☐ Halo report run and DCW task sheets are completed			
☐ Task Sheets match Service Plan			
3. Service note entered			
4. HALO and Service Authorization match ☐ authorized units			
5. Units Billed – Service notes, task sheets and billing match Time Frames reviewed: _____			
6. RN visit for Options participant, RN reviewed and signed assessment tool			

Comments: _____

_____

Incident Report	Completed	Needs Revised	Not Applic
1. Verify necessary EIMs or Incident Reports were created and follow-up activity completed for fiscal year with all reportable incidents reported. ☐ Verify in service note/journal entry ☐ EIM/IR submitted			

Comments: _____

_____

Complaints	Completed	Needs Revised	Not Applic
1. Monthly Complaint Report reviewed • Participant filed a complaint			

Comments: _____

_____

Service Authorization:	Completed	Needs Revised	Not Applic
1. Service Authorization Form completed and received for services that are new, changed or terminated (electronic copy in file)			
2. Service Authorization is current ☐ Date of SA expiration: _____			
3. During enrollment and reevaluation the RN or Safety Mentor reviews the process for reporting restraints and Restrictive interventions			
4. If significant change in the medical or social condition of a participant, a AI staff person has notified the participants Service			
5. Personal Representative documented if participant has impaired judgment per Service Coordinator			
6. If applicable, Power of Attorney in file			
7. Translation service were offered if primary language is not English & documented			

Comments: _____

_____

_____

_____

Monitoring form submitted to Executive Director and NPMS Compliance and Policy Manager (within 2 work days from the QM meeting date at the top of this form)

Monitoring Completed by: _____

_____

(Signature) (Date)

Executive Director: _____

_____

(Signature) (Date)

Independent Living Services Consumer Survey

Page 1: ILS Customer Quality Survey FY 18/19 Page 1 of 1

Good morning/afternoon _____.

This is _____ on behalf of Independent Living Services, your personal care agency.

I wanted to take a moment to thank you for giving us the opportunity to serve you. We appreciate your business and want to make sure that we are meeting your expectations.

Would you mind taking a few minutes to answer a few questions about the service that your caregivers provide you?

1. Participant / Customer Name:

2. ILS staff understand my needs and acts in my best interest.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Additional Comments

Remaining Characters: 1000

3. _____(Staffing Supervisor's name) responds to my calls in a timely manner and is professional in dealing with me.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Additional Comments

4. The after hours on call staff return my calls promptly and always handle my issues promptly and professionally.

Strongly Agree
Agree
Neither Agree nor Disagree
Disagree
Strongly Disagree
Additional Comments

Remaining Characters: 1000

5. The personal care attendants who provide my care are well trained and are making a positive difference in my life.

Strongly Agree
Agree
Neither Agree nor Disagree
Disagree
Strongly Disagree
Additional Comments

Remaining Characters: 1000

6. Based on your experience with ILS would you to recommend ILS to a friend or family member?

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Additional Comments

Remaining Characters: 1000

7. Are the Caregivers we provide on time and reliable?

Yes No

Additional Comments

Remaining Characters: 1000

8. Is there any other information you would like us to know?

Remaining Characters: 4000

CHAPTER EIGHT

Risk Management

Critical Incident Management

Purpose:

Accessing Independence (AI) is committed to providing quality services to participants. All participants shall be treated with dignity and respect. At times, an event may occur that is not in the best interest of the participant. In conjunction with the Office of Long-Term Living-Bureau of Home and Community Based Services, AI has developed mechanisms to tract and handle a negative event or incident.

The participant must also be made aware of their rights and it is the policy of AI and Office of Long-Term Living-Bureau of Home and Community Based Services to report all Grievances, Complaints, and Incidents. The OLTL participant hotline number 1-800-757-5042 is provided at the time of enrollment to the participant. This information is found in the Rights and Responsibilities Form.

Definitions of critical events or incidents as outlined by BHCBS:

The Office of Long Term Living defines a reportable critical event/ incident **(Bulletin issued 10-11-11; Critical Incident Management Policy for Office of Long-Term Living Home and Community-Based Services Programs)** as "the occurrence of an event that **jeopardizes the participant's health and/or welfare….** This includes but us not limited to Death, Provider and Staff Misconduct, Abuse, Neglect, Exploitation, Serious injury, Service Interruption"; and hospitalizations (except in certain cases, e.g., a hospital stay that was planned in advance).

It is mandatory for employees of direct service providers, service coordination entities and facilities to report critical incidents related to individuals who receive home and community based services and supports. All Accessing Independence (AI) staff members are therefore required to report such incidents.

Please reference the Office of Long Term Living Bulletin issued April 16, 2015 to provide clarification of critical incidents, clarification of service coordinator and provider responsibilities for critical incident and risk management. SC's and providers are mandatory reporters under the Adult Protective Services (APS) Act and the Older Adults Protective Services Act (OAPSA).

APS: Act 70 of 2010 requires that all SC's and providers are mandatory reporters under the law, which provides protections for adults between the ages of 18 and 59 who have disabilities.

OAPSA: OAPSA requires that all SC's and providers report suspected abuse neglect and exploitation of adults over age 60 to Older Adults Protective Services.

This applies to Adult Autism, Aging, Attendant Care, COMMCARE, Independence, and OBRA waivers and for the Act 150 Program.

Definitions of reporting critical incidents: as outlined by BHCBS Bulletin issued 04/16/2015; Critical Incident Management Policy for Office of Long-Term Living Home and Community-Based Services Programs):

Abuse- An act or omission that willfully deprives a participant of rights or human dignity, or which may cause or causes actual physical injury or emotional harm to a participant including a critical incident and any of the following:

1) Sexual harassment of a participant
2) Sexual contact between a staff member and a participant.
3) Using restraints on a participant.
4) Financial exploitation of a participant.
5) Humiliating a participant.
6) Withholding regularly scheduled meals from a participant.

Critical Incident- An occurrence of an event that jeopardizes the participant's health or welfare including:

1) Death, serious injury or hospitalization of a participant. Pre-planned hospitalizations are not critical incidents*.
2) Provider and staff member misconduct including deliberate, willful, unlawful or dishonest activities.
3) Abuse, including the infliction of injury, unreasonable confinement, intimidation, punishment or mental anguish, of the participant. Abuse includes the following:
   a) Physical abuse.
   b) Psychological abuse.
   c) Sexual abuse.
   d) Verbal abuse.
4) Neglect.
5) Exploitation.
6) Service interruption, which is an event that results in the participant's inability to receive services and that places the participant's health and welfare at risk.
7) Medication errors that result in hospitalization, an emergency room visit or other medical intervention.

*Being admitted for a non-routine medical condition that was not scheduled or planned to occur is a critical incident: a routine hospital visit for lab work or routine treatment of illness is not a critical incident. A death that is suspicious or of unexplained causes is a critical incident. A death due to natural causes is **not** a critical incident.

*Critical incidents are not complaints, which are dissatisfaction with program operations, activities or services received, or not received, involving HCBS. Critical incidents are NOT Program fraud and financial abuse. Examples of program fraud and financial abuse include 1) claims submitted for services or supplies that were not provided and 2) excessive charges for services and supplies. Separate reporting requirements can be found in the OLTL Fraud & Financial Abuse bulletin:(05-11-04, 51-11-04, 52-11-04, 54-11-04, 55-11-04, 59-11-04, issued and effective on August 8, 2011). Program fraud and financial abuse should **not** be reported as critical incidents.

Exploitation – an act of depriving, defrauding or otherwise obtaining the personal property of a participant in an unjust or cruel manner, against one's will or without one's consent or knowledge for the benefit of self or others.

Investigation –To take the steps necessary to determine if a critical incident has occurred, to determine if suspected abuse, neglect, abandonment or exploitation requiring the involvement of protective services is involved, what actions are needed to protect the health and welfare of participants and what actions are needed to mitigate future incidents.

Neglect – The failure to provide an individual the reasonable care that he or she requires, including but not limited to food, clothing, shelter, medical care, personal hygiene and protection from harm. Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect.

Restraint – Any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions which are actions or procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights.

Service Interruption – Any event that results in the participant's inability to receive services that places his or her health or safety at risk. This includes involuntary termination by the provider agency and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization

In reporting incidents, you must follow the following process:

1. Contact the Executive Director or any program director immediately.

2. Use the definitions from the OLTL bulletin to determine if the incident is reportable.

3. Have the participant involved; participants have autonomy and they have a right to not report an incident and can decline further interventions if they so choose. They can also refuse involvement in the incident investigation. They also have a right to have an advocate present during all/part of the interviews and investigations resulting from the incident report.

4. The AI staff person will use the OLTL electronic system to document all incidents, which must include: (see steps listed below related to EIM system)

a. Reporter information

b. Participant demographics

c. OLTL program information

d. Event details and type

e. Description of incident

Action taken, resolution and steps to prevent reoccurrence must be completed upon conclusion of investigation but no later than 30 days from the time of discovery of the incident.

The AI staff member will complete the EIM report (login with HCSIS username and password)

Important Numbers:

- Consumer's ICD-9 Code
- Location Code (by Program)
- Provider Number
- Provider Location code

5. Timeframes:

a. Notify you supervisor immediately (24 hours maximum) of the incident

b. The provider agency (AI) must notify OLTL and SC agency and other appropriate agencies within 48 hours of the incident.

c. Within 30 days, if additional information is needed, the investigative action, resolutions and measures to prevent reoccurrence must be submitted to OLTL.

d. In regards to the participant:

1. Must notify the participant within 24 hours of the incident being filed that a report has been filed.

2. Within 48 hours of conclusion of investigation, agency staff must inform participant of the resolution and ways to prevent reoccurrence.

6. Confidentiality: please remember that all information gathered as a result of an investigation of an alleged incident involving a participant is confidential.

Some additional information/steps you may need to take if appropriate: these are related to abuse, neglect or exploitation cases.

Contact the AI Executive Director or Program Director immediately.

AI is required to call Protective Services immediately to give verbal report (Elder Abuse Hotline) 1 800-490-8505.

AI office staff must provide and will have access to the following info:

- Victim's Name
- Address
- Phone
- Date of Birth
- Social Security Number (as much as known)
- PCP (if known)

- Primary Diagnosis

Critical Incident Reporting Process

Definitions:

An Incident is defined as an injury; an allegation of abuse, neglect, or exploitation; misconduct or theft by any provider or their representative. For PDA or CSPPPD consumers only, hospitalization will also be reportable incidents.

A Complaint is defined as criticism, accusation, or charge of inadequacy of services of services provided by an Attendant Care contractor, medical assistance enrolled provider, or sub-contractor. A complaint regarding nursing facility services provided by the facility (excluding specialized services) should be forwarded directly to the Department of Health.

Procedures:

1. Determine if the incident/complaint requires the completion of a formal participant Incident or Complaint Form.

2. Legibly complete an incident/complaint report. Use additional pages if more space is needed to accurately describe the incident/complaint, investigative action, resolution and recommendations.

3. The completed Incident/Compliant form and any attachments (additional documentation, written reports sent to other agencies, etc.) should be given to the supervisor of the person who took the report and completed the form.

4. If the form must be sent to a separate entity (i.e. for CSPPPD consumers) the supervisor will initiate all appropriate actions from this point.

5. Within five working days of receipt of the incident/complaint, supervisory or administrative level staff will review each report, complete any investigative action, indicate resolution, and make recommendation for prevention of future problems.

6. The provider will generate a log report that synthesizes all of the incidents/complaints received and the report is reviewed by the AI Quality Management Committee.

7. A member of the administrative staff will analyze this quarterly incident/complaint report for patterns or trends. If patterns or trends are identified the department staff will be instructed to take appropriate and timely action to make corrections.

8. On an annual basis, coinciding with the fiscal year, the quarterly incident/complaint report will be combined into an annual report.

9. AI QM committee will review the annual aggregate report, referring to specific incident/complaint reports as needed to determine the most appropriate course of action.

10. When an incident/complaint/complaint is initiated by a consumer, agency personnel are required to discuss the incident/complaint with the consumer and record the consumer's viewpoint. In addition, when an incident/complaint is resolved with a consumer, this must be documented.

11. All AI staff members are also required to share the OLTL toll free hot line number during intake. That number is 1-800-757-5042.

Required Forms: Incident Report Form

INCIDENTS & REPORTING ABUSE POLICY

It is mandatory for employees of home care agencies and facilities to report critical incidents related to individuals who receive home and community based services and supports. All Accessing Independence Attendant Care staff members are therefore required to report such incidents.

Please reference the Office of Long Term Living Bulletin issued April 16, 2015 to provide clarification of critical incidents, clarification of service coordinator and provider responsibilities for critical incident and risk management. SC's and providers are mandatory reporters under the Adult Protective Services (APS) Act and the Older Adults Protective Services Act (OAPSA)

APS: Act 70 of 2010 requires that all SC's and providers are mandatory reporters under the law, which provides protections for adults between the ages of 18 and 59 who have disabilities.

OAPSA: OAPSA requires that all SC's and providers report suspected abuse neglect and exploitation of adults over age 60 to Older Adults Protective Services.

This applies to Adult Autism, Aging, Attendant Care, Independence, and OBRA waivers and for the Act 150 Program.

Definitions of reporting critical incidents: as outlined by BHCBS Bulletin issued 04/16/2015; Critical Incident Management Policy for Office of Long-Term Living Home and Community-Based Services Programs):

Abuse- An act or omission that willfully deprives a participant of rights or human dignity, or which may cause or causes actual physical injury or emotional harm to a participant including a critical incident and any of the following:

7) Sexual harassment of a participant
8) Sexual contact between a staff member and a participant.
9) Using restraints on a participant.
10) Financial exploitation of a participant.
11) Humiliating a participant.
12) Withholding regularly scheduled meals from a participant.

Critical Incident- An occurrence of an event that jeopardizes the participant's health or welfare including:

8) Death, serious injury or hospitalization of a participant. Pre-planned hospitalizations are not critical incidents*.
9) Provider and staff member misconduct including deliberate, willful, unlawful or dishonest activities.
10) Abuse, including the infliction of injury, unreasonable confinement, intimidation, punishment or mental anguish, of the participant. Abuse includes the following:
    e) Physical abuse.
    f) Psychological abuse.
    g) Sexual abuse.
    h) Verbal abuse.
11) Neglect.
12) Exploitation.
13) Service interruption, which is an event that results in the participant's inability to receive services and that places the participant's health and welfare at risk.
14) Medication errors that result in hospitalization, an emergency room visit or other medical intervention.

*Being admitted for a non routine medical condition that was not scheduled or planned to occur is a critical incident: a routine hospital visit for lab work or routine treatment of illness is not a critical incident. A death that is suspicious or of unexplained causes is a critical incident. A death due to natural causes is **not** a critical incident.
*Critical incidents are not complaints, which are dissatisfaction with program operations, activities or services received, or not received, involving HCBS. Critical incidents are NOT Program fraud and financial abuse. Examples

of program fraud and financial abuse include 1) claims submitted for services or supplies that were not provided and 2) excessive charges for services and supplies. Separate reporting requirements can be found in the OLTL Fraud & Financial Abuse bulletin:(05-11-04, 51-11-04, 52-11-04, 54-11-04, 55-11-04, 59-11-04, issued and effective on August 8, 2011). Program fraud and financial abuse should **not** be reported as critical incidents.

Exploitation – an act of depriving, defrauding or otherwise obtaining the personal property of a participant in an unjust or cruel manner, against one's will or without one's consent or knowledge for the benefit of self or others.

Investigation –To take the steps necessary to determine if a critical incident has occurred, to determine if suspected abuse, neglect, abandonment or exploitation requiring the involvement of protective services is involved, what actions are needed to protect the health and welfare of participants and what actions are needed to mitigate future incidents.

Neglect – The failure to provide an individual the reasonable care that he or she requires, including but not limited to food, clothing, shelter, medical care, personal hygiene and protection from harm. Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect.

Restraint – Any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions which are actions or procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights.

Service Interruption – Any event that results in the participant's inability to receive services that places his or her health or safety at risk. This includes involuntary termination by the provider agency and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization

In reporting incidents, you must follow the following process:

1. Contact the Accessing Independence Attendant Care Home Services Director, Program Director, or any Attendant Care office staff member immediately.

2. Use the definitions from the OLTL bulletin to determine if the incident is reportable.

3. Have the participant involved; participants have autonomy and they have a right to not report an incident and can decline further interventions if they so choose. They can also refuse involvement in the incident investigation. They also have a right to have an advocate present during all/part of the interviews and investigations resulting from the incident report.

4. The Attendant Care office staff member will use the OLTL electronic system to document all incidents, which must include: (see steps listed below related to EIM system)

a. Reporter information

b. Participant demographics

c. OLTL program information

d. Event details and type

e. Description of incident

Action taken, resolution and steps to prevent reoccurrence must be completed upon conclusion of investigation but no later than 30 days from the time of discovery of the incident.

The Attendant Care office staff member will complete the EIM report (login with HCSIS username and password)

Important Numbers:

- Consumer's ICD-9 Code (found in attendant care drive "ICD9 Codes.xlsx") – some attached
- Location Code (by Program)
- Provider Number
- Provider Location code

The Department of Health (DOH) report will be done by the agency providing PAS services (i.e., AI) This is done by Attendant Care office staff.

5. Timeframes:

a. Notify you supervisor immediately (24 hours maximum) of the incident

b. The PAS agency (AI) must notify OLTL and SC agency and other appropriate agencies within 48 hours of the incident.

c. Within 30 days, if additional information is needed, the investigative action, resolutions and measures to prevent reoccurrence must be submitted to OLTL.

d. In regards to the participant:

1. Must notify the participant within 24 hours of the incident being filed that a report has been filed.

2. Within 48 hours of conclusion of investigation, agency staff must inform participant of the resolution and ways to prevent reoccurrence.

6. Confidentiality: please remember that all information gathered as a result of an investigation of an alleged incident involving a participant is confidential.

Some additional information/steps you may need to take if appropriate: these are related to abuse, neglect or exploitation cases.

Contact the AI Attendant Care Home Services Director, Program Director, or any Attendant Care office staff member immediately, using the 24 hour answering service, if needed.

AI is required to call Protective Services immediately to give verbal report (Elder Abuse Hotline) 1 800-490-8505.

AI office staff must provide and will have access to the following info:

- Victim's Name
- Address

- Phone
- Date of Birth
- Social Security Number (as much as known)
- PCP (if known)
- Primary Diagnosis

Critical Incident Reporting Process

Definitions:

An Incident is defined as an injury; an allegation of abuse, neglect, or exploitation; misconduct or theft by any provider or their representative. For PDA or CSPPPD consumers only, hospitalization will also be reportable incidents.

A Complaint is defined as criticism, accusation, or charge of inadequacy of services of services provided by an Attendant Care contractor, medical assistance enrolled provider, or sub-contractor. A complaint regarding nursing facility services provided by the facility (excluding specialized services) should be forwarded directly to the Department of Health.

Procedures:

1. Determine if the incident/complaint requires the completion of a formal Consumer Incident or Complaint Form.

2. Legibly complete an incident/complaint report. Use additional pages if more space is needed to accurately describe the incident/complaint, investigative action, resolution and recommendations.

3. The completed Incident/Compliant form and any attachments (additional documentation, written reports sent to other agencies, etc.) should be given to the supervisor of the person who took the report and completed the form.

4. If the form must be sent to a separate entity (i.e. for CSPPPD consumers) the supervisor will initiate all appropriate actions from this point.

5. Within five working days of receipt of the incident/complaint, supervisory or administrative level staff will review each report, complete any investigative action, indicate resolution, and make recommendation for prevention of future problems.

6. The provider will generate a log report that synthesizes all of the incidents/complaints received and the report is reviewed by the AI Quality Management Committee Monthly.

7. A member of the administrative staff will analyze this quarterly incident/complaint report for patterns or trends. If patterns or trends are identified the department staff will be instructed to take appropriate and timely action to make corrections.

8. On an annual basis, coinciding with the fiscal year, the quarterly incident/complaint report will be combined into an annual report.

9. AI QM committee will review the annual aggregate report, referring to specific incident/complaint reports as needed to determine the most appropriate course of action.

10. When an incident/complaint/complaint is initiated by a consumer, agency personnel are required to discuss the incident/complaint with the consumer and record the consumer's viewpoint. In addition, when an incident/complaint is resolved with a consumer, this must be documented.

11. All Attendant Care staff members are also required to share the OLTL toll free hot line number during intake. That number is 1-800-757-5042.

Critical Incident Management Database

Hyperlink:

S:\ILS Incident Tracking

Safeguards Concerning Participant Abuse, Restraints and Restrictive Intervention

Policy:

Sexual Harassment, Sexual Contact, Financial Exploitation, Humiliation, withholding regularly scheduled meals and Use of Restraints or Seclusion of a participant is strictly prohibited.

Accessing Independence, as a provider agency, reviews the standardized Rights and Responsibilities Forms with the participant during enrollment

The process for reporting § 52.16 is reviewed with the participant and includes how the participant should report it to AI staff.

§ 52.16

(a) Abuse is an act or omission that willfully deprives a participant of rights or human dignity, or which may cause or causes actual physical injury or emotional harm to a participant including a critical incident and one or more of the following:

(1) Sexual harassment of a participant.

(2) Sexual contact between a staff member and a participant.

(3) Restraining a participant.

(4) Financial exploitation of a participant.

(5) Humiliating a participant.

(6) Withholding regularly scheduled meals from a participant.

(b) Abuse of a participant is prohibited

Process for Reporting Abuse under § 52.16

1) Should Abuse be reported, the participant, caregiver or person acting on his/her behalf may discuss his/her complaint with any AI staff member. The staff member receiving the information should encourage the participant (and grieving party, if different) to supply complete information. The staff member should immediately notify the AI Program Director who will assume responsibility for completing an **Incident Report**.

2) The Incident Report will identify the abuse, person alleged to have conducted the violation and the plan of action the staffing supervisor implemented to resolve the restriction.

3) The AI Program Director will document in Halo service notes the incident and plan of action. All subsequent follow up will be noted in Halo service notes.

4) The AI Executive Director will review the **Report,** sign and date the report validating the plan of action.

5) The AI Program Director will fax the completed and signed **Incident Report** with plan of action, to OLTL designee within twenty four hours of the initial notification.

6) The Staffing Supervisor will follow up with the Supports Coordinator, ascertaining that the plan of action to prevent restraint and/or restrictive intervention has been implemented.

7) The Safety mentor will include the Report in the Incident Report binder for monthly review and follow up by the Quality Assurance Team

State and Federal Bulletins and Directives

05-11-04 Fraud and Abuse Directive

Pennsylvania DEPARTMENT OF AGING DEPARTMENT OF PUBLIC WELFARE

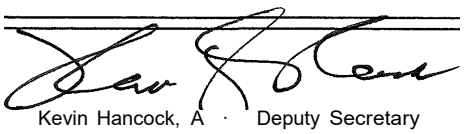
OFFICE OF LONG-TERM LIVING BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
August 8, 2011	**Immediately**	05-11-04, 51-11-04, 52-11-04, 54-11-04, 55-11-04, 59-11-04

SUBJECT

Program Fraud & Financial Abuse in Office of Long-Term Living MA Home and Community-Based Service (HCBS) Programs

BY



Kevin Hancock, A · Deputy Secretary
Office of Long-Term Living

PURPOSE

The purpose of this Bulletin is to remind the Medical Assistance (MA) Home and Community
Based-Service providers of the requirements set forth in Sections 1101.73 (relating to provider misutilization and abuse) and 1101.75 (relating to provider prohibited acts) of Title 55 Pa Code and the procedures for reporting suspected misutilization, abuse and prohibited acts.

SCOPE

This OLTL Bulletin applies to all MA Home and Community-Based Services (HCBS) Waiver
service providers, including Care Management and Service Coordination Agencies, Care Managers and Service Coordinators, Fiscal/Employer Agencies, Direct Service Agencies and employees and contractors of these agencies.

DISCUSSION

The OLTL is responsible for providing MA HCBS providers with information about financial
abuse and program fraud; documentation requirements; how to report suspected fraud or abuse and remedies available for enforcement.

Title 55 Pa Code § 1101.73 (relating to provider misutilization and abuse) discusses the steps taken if a provider is found billing for services inconsistent with MA regulations, unnecessary, inappropriate to patients' health needs or contrary to customary standards of practice. Examples of provider misutilization and abuse include, but are not limited to, the following:

- Charging excessively for services or supplies;
- Submitting claims for services thatdo not meet CMS/MA medical necessity criteria;
- Breaching the Medicare/Medicaid participation or assignment agreements;
- Improperly submitting claims or utilizing incorrect coding; and
- Submitting incomplete records required to document service provision, or as otherwise required by state and/or federal rules.

Title 55 Pa. Code§ 1101.75 (relating to provider prohibited acts) outlines the acts prohibited under the MA program. Examples of provider prohibited acts include, but are not limited to, the following:

- Submitting claims for services or supplies that were not provided;
- Altering claims to obtain higher payments;
- Soliciting, offering or receiving a kickback, bribe or rebate (for example, paying for referral of clients);

- Completing Certificates of Medical Necessity (CMNs) for patients not known to the provider;
- Submitting any false data on claims, such as the date of service, units of service, or the provider of service; and
- Using deceptive enrollment practices.

The following are situational examples of program fraud committed by providers:

- A personal care worker continued to bill and be paid for services authorized under an MA waiver while the individual supposed to be receiving the services was incarcerated. Both the worker and the person supposed to be receiving the services conspired to continue billing for the services in order to gather money for bail.
- A personal care worker billed and received payment for hours of service provided to an individual needing assistance while the personal care worker was on duty at another job.

Examples of program fraud committed by individuals receiving services:

- Using another person's Medicare/Medicaid card to obtain medical care; and
- Signing an attendant's timesheet for hours of care not provided.

Documentation Requirements for Services Rendered

Title 55 Pa. Code§ 1101.51(d) establishes standards of practice and§ 1101.51(e) sets forth record keeping requirements for all provider types, including MA HCBS Waiver providers. The OLTL must assure that providers have sufficient and accurate documentation to support claims submitted for payment. This documentation is used by the Department to determine the validity of claims submitted, the medical necessity and quality of services provided to MA recipients.

PROCEDURES

Providers should review their record keeping practices to ensure compliance with applicable
Federal and State statutes and regulations, as well as compliance with their licensing and approval standards.

Reporting

Providers that detect or suspect a prohibited act has been committed MUST report the suspected prohibited act to the DPW Office of Administration, Bureau of Program Integrity. This DOES NOT preclude reporting to any other investigative agency or entity.

Detected or suspected prohibited acts must be reported immediately to the Bureau of Program
Integrity (BPI) through one of the methods listed below.

- By electronically submitting the MA Provider Compliance Hotline Response Form (http://www.dpw.state.pa.usllearnaboutdpw/fraudandabuse/maprovidercomplianceh otlineresponseform/index.htm)
- By phone: 1-866-DPW-TIPS (1-866-379-8477)
- By fax: (717) 772-4655-Attention: MA Provider Compliance Hotline
- By U.S. Mail:

Bureau of Program
Integrity MA Provider
Compliance Hotline
P.O. Box 2675
Harrisburg, PA
17105-2675

Remedies for Enforcement

OLTL reminds providers that DPW has the following enforcement actions listed in 55 Pa. Code § 1101.77 (relating to enforcement actions taken by the Department) available to address fraud and financial abuse. These actions include terminating the provider's provider enrollment and participation in the MA program.

Providers convicted of prohibited acts are subject to criminal penalties outlined in 55 Pa. Code § 1101.76 (relating to criminal penalties).

Providers who have engaged in prohibited acts can also be referred to federal authorities for further investigation and possible prosecution, according to 55 Pa. Code§ 1101.74 (relating to Provider fraud).

DPW can also seek restitution and reimbursement for payments made for prohibited acts under 55 Pa Code § 1101.83 (relating to restitution and repayment).

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Office of Long-Term Living
Office of Policy and Strategic Planning

Forum Place
555 Walnut Street, 5th floor
Harrisburg, PA 17101
717-705-3705

Aging Mandatory Abuse Form – ACT-13

PENNSYLVANIA DEPARTMENT OF AGING

ACT-13
MANDATORY ABUSE REPORT

DATE OF REPORT:	TIME:

NAME OF VICTIM (Last, First, M.I.):	FACILITY NAME:
ADDRESS:	ADDRESS:
CITY: STATE: ZIP CODE :	CITY: STATE: ZIP CODE:
PHONE:	PHONE: COUNTY:
DATE OF BIRTH: SEX:	FACILITY TYPE: (NH, PCH, DC, CLA, etc.)
ABUSE TYPE: (Check one.) ☐ ABUSE including sexual harassment NOT involving sexual abuse, serious bodily injury, serious physical injury, or suspicious death ☐ SEXUAL ABUSE (rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, indecent assault or incest) ☐ SERIOUS BODILY INJURY ☐ SERIOUS PHYSICAL INJURY ☐ SUSPICIOUS DEATH	LICENSING AGENCY: LICENSE NUMBER: DATE AND TIME OF REPORT TO LICENSING AGENCY: DATE: / / TIME: ___:___ A.M. P.M.
DATE AND TIME OF INCIDENT: DATE: / / TIME: ___:___ A.M. P.M.	LICENSING AGENCY CONTACT AND TELEPHONE NUMBER: NAME: TELEPHONE #:
DATE/TIME ORAL REPORT TO AAA: / DATE/TIME ORAL REPORT TO LOCAL LAW ENFORCEMENT: (If applicable)	DATE/TIME ORAL REPORT TO PDA: (If applicable) / *AAA USE ONLY:* DATE/TIME ORAL REPORT TO COUNTY CORONER: (If applicable)
NAME OF AAA CONTACTED: / NAME OF LAW ENFORCEMENT AGENCY: (If applicable)	*AAA USE ONLY:* NAME OF CORONER: (If applicable)
CONTACT INFORMATION: (PLEASE CHECK APPROPRIATE BLOCK) ☐ GUARDIAN ☐ NEXT OF KIN	ALLEGED PERPETRATOR NAME: / RELATIONSHIP TO VICTIM:
NAME:	ADDRESS:
ADDRESS:	CITY: STATE: ZIP CODE:
CITY: STATE : ZIP CODE:	PHONE NUMBER: / AGE: / SEX:
PHONE NUMBER: RELATIONSHIP:	TYPE OF POSITION: (RN, LPN, CNA, etc.) / WORK SHIFT: / DATE OF HIRE:

PDAACT13.1 (4/08)

PLEASE COMPLETE REVERSE SIDE

DETAILS AND DESCRIPTION OF ABUSE: (ATTACH ADDITIONAL SHEETS IF NECESSARY)	
ACTIONS TAKEN BY FACILITY, INCLUDING TAKING OF PHOTOGRAPHS AND X-RAYS, REMOVAL OF VICTIM AND NOTIFICATION OF APPROPRIATE AUTHORITIES. (ATTACH ADDITIONAL SHEETS IF NECESSARY)	
OTHER PERTINENT INFORMATION, COMMENTS OR OBSERVATIONS DIRECTLY RELATED TO ALLEGED ABUSE INCIDENT AND VICTIM:	
NAME AND TITLE OF REPORTER: (PLEASE TYPE OR PRINT) NAME: TITLE:	SIGNATURE OF REPORTER:
REPORTER CONTACT INFORMATION: TELEPHONE NUMBER: EMAIL ADDRESS:	DATE:
NAME AND TITLE OF PERSON PREPARING REPORT: (PLEASE TYPE OR PRINT) NAME: TITLE:	SIGNATURE OF PERSON PREPARING REPORT:
PERSON PREPARING REPORT CONTACT INFORMATION: TELEPHONE NUMBER: EMAIL ADDRESS:	DATE:

Management Complaint Policy

Policy:

Accessing Independence (AI) Participants, caregivers or persons acting on their behalf have the right to express dissatisfaction, orally or in writing, with service delivery or quality of care furnished. Participants and persons acting on their behalf have the right to appeal certain actions by the Accessing Independence staff, including denial of a requested for a service or to continue a service and involuntary termination.

It is the policy of AI to adhere to the OLTL Policy: 55 P A CODE Ch 52, Section 52.18 Complaint management; and, OLTL Bulletin # 05-11-06, 51-11-06, 52-11-06, 54-11-06, 55-11-06, 59-11-06, Critical Incident Management Policy for Office of Long Term Living Home and Community-Based Services Programs

Definition of a Complaint:

Dissatisfaction with any aspect of program operations, activities, or services received or not received involving Home and Community Based Services are considered complaints.

A complaint is any criticism, accusation or charge of inadequacy of services provided by a AI staff or its sub-contractors. A complaint is any expression of dissatisfaction, either orally or in writing, with service delivery or the quality of care furnished by AI and its subcontractors. If a staff member is unable to distinguish between a complaint and inquiries, then those concerns shall be treated as complaint. Even “informal” feedback received from participants, caregivers, participant satisfaction surveys or providers will be addressed as complaints.

Procedure:

Accessing Independence staffing supervisors have responsibility for:

- Maintaining the incident, complaint, grievance and appeals procedures

The Executive Director has responsibility for:

- Ongoing review of complaint operations
- Identifying any patterns of complaints , bringing such patterns to the attention of the AI Quality Management Team so the patterns will be addressed in the formulation of policy changes and procedural improvements,
- Maintaining the written/electronic records of all incidents, complaints, grievance and appeals

- Aggregating and analyzing information on incidents, complaints, grievances and appeals to be used in the Quality Assessment and Performance Improvement Program
- Providing incident, complaint, grievance and appeal training to staff at both initial orientation and annually.

The Staffing Supervisors have the primary responsibility for assuring that the process for receipt, documentation and resolution of complaints and appeals are fully implemented and adhered to by AI staff.

Any staff receiving a complaint will immediately notify the a Staffing Supervisor who will assure an electronic record is created, including date, identification of the individual recording the complaint and disposition. The written/electronic records of complaints shall be maintained by the Executive Director and be made available for review by the DPW OLTL Bureau of Home and Community Base Services and Department of Health auditors when requested.

All AI staff will ensure confidentiality of all complaint information and that there is no discrimination against a consumer because he/she files a complaint.

Notification:

Upon enrollment (through the Consumer Rights and Responsibilities Document) AI enrollment staff will provide every participant with written information regarding the Complaint Process.

Complaint Process

Filing, Documenting, Responding to and Resolving Complaints

The participant, caregiver or person acting on his/her behalf may discuss his/her complaint with any AI staff member. The staff member receiving the complaint should encourage the participant (and grieving party, if different) to supply complete information. The staff member should immediately notify the Staffing Supervisor who will assume responsibility for processing the complaint.

If a participant desires assistance in filing a complaint from someone other than AI staff, AI will immediately notify the state designated long term care ombudsman, and cooperate with them in assisting the participant in the process.

The Staffing Supervisor will immediately (within 24 hours during work week) document its receipt on the electronic Participant Complaint Log.

Documentation will include as much information as possible, but at a minimum, the date the complaint was received, name of participant or grieving party and their relationship to the participant, phone number and the description of the complaint. Upon entry into the system, the Executive Director will be notified via e-mail that a complaint has been received.

Within 24 hours of receipt of the complaint, the Staffing Supervisor will provide to the participant (and grieving party, if different) acknowledgement of AI's receipt of the complaint, including the specific steps and timeframes for resolving the complaint. This interaction will be documented in the AI complaint log.

The Staffing Supervisor working closely with the appropriate staff member have five days from the receipt of the complaint to recommend a solution. If the participant (or grieving party, if different) agrees to the proposed solution within that timeframe, the complaint is considered resolved.

The Staffing Supervisor will complete the remainder of the electronic Complaint Form Log, documenting the resolution. A printed copy of the completed Form should be sent to the participant (and grieving party, if different) as written documentation of the resolution.

If a solution is not found by the Staffing Supervisor working with the staff or agreed to by the participant (and grieving party, if different) within five working days, the Executive Director will be notified by the Staffing Supervisor for further action.

After further investigation and attempts to resolve the complaint, the Executive Director will complete a written report that either approves or disapproves the AI staff's solution, and forwards a copy within 5 working days to the participant (and grieving party, if different). This report is considered to be AI final disposition to the complaint.

A notice accompanies the final report stating that if the participant (or grieving party, if different) is not satisfied with this action, he/she has 30 days to pursue filing a PA561.

OLTL Hearing and Appeal Bulletin, Instructions and Forms:

http://www.dhs.pa.gov/publications/bulletinsearch/index.htm

Participant's Responsibility in Filing an Appeal

IF a participant requests to appeal through the DPW OLTL process, the Staffing Supervisor will refer the participant to their service coordinator and contact the service coordinator within one business day.

The following is a link to State provisions:
http://www.pacode.com/secure/data/055/chapter275/chap275toc.html

AI Responsibility Related to the Appeal

- AI may not take the proposed adverse action until at least 30 calendar days have elapsed from the date the consumer was notified of the intent to reduce or terminate services.
- AI will date-stamp any submitted appeal request and forward it to the Department of Public Welfare, Bureau of Hearings and Appeals in Harrisburg. An appeal request received on or before the thirtieth day of the time limit will be considered "timely" and will be forwarded.

Service Provision During an Appeal – If, within 10 calendar days of the date the participant was notified of the adverse action, AI receives an appeal requesting a hearing, the existing level of services must continue until the appeal is heard and a decision is rendered by the Bureau of Hearings and Appeals. Should services reduction and/or termination be due to the existence of unsafe or unsanitary conditions or because activities are occurring which jeopardize the health or safety of an attendant and/or the AI staff, the Executive Director needs to consult with the Bureau of Home and Community BS to develop a plan of action.

"The BHCBS recognizes that home and community based programming is unique in the demands placed upon services providers. That is, unlike financial assistance entitlement programming and/or many other services of the Department, the HCBS Waiver programs are "in-home" services models. Staff acting on behalf of the HCBS Waivers routinely provides service at all hours of the day or night and most often in the presence of no other persons (apart from the participant). In recognition of this fact, the Department will not knowingly require HCBS funded personnel to risk assault or other significant harm in the fulfillment of duty.

The BHCBS will send an explanatory letter to the participant (with a copy to AI) should services suspension be deemed necessary. The Department will also inform Departmental Legal Counsel and other authorities, as appropriate."

Notification of the BHCBS Staff

AI, Executive Director, must verbally notify the appropriate state BHCBS regional contract manager when AI is aware that a participant is filing an appeal. When the appeal is forwarded to the Bureau of Hearings and Appeals, AI will forward a copy to the Office of Long Term Living, BHCBS.

AI will send copies of all decisions received from the Bureau of Hearings and Appeals, to the regional contract manager within three working days of receipt of the decision.

Complaint Log

Purpose: To define where complaints are documented and recorded.

Procedure: Upon receiving a complaint, staffing supervisor will document grievance onto the complaint log, which is located at: S:\Complaints\Complaint Tracking. All notes, follow up, and manager approval will be documented on that log as well.

Complaint Management Process

First point of contact should document complaint/issue brought to their attention using Incident Management Log to record event:

1. Once report of complaint/issues occur the supervisor determine the level of the allegations by:

a. Determine if complaint requires EIM/critical incident reporting

b. Talking to the Safety Mentor to determine level of involvement by same (Once determination is made that incident requires safety mentor/certified investigator intervention, complaint is turned over to Safety Mentor (further details on actions from Safety Mentor below).

c. Speak with all parties involved in the complaint/issue when concerns are related to PCA work performance/level of care concerns

d. Create resolution/action plan to consumer's satisfaction to resolve the complaint/issues.

2. Complete and wrap up the findings and complete report with resolution and save report on the "s" drive, incident report folder.

3. Once investigation is complete, copy of report is sent to ILS Executive Director, Support Coordinator (where applicable) and supervisor should follow up with all parties regularly to be sure no further occurrences.

Safety Mentor/Certified Investigator Process:

1. Discuss incident with first point of contact to determine level of involvement.

2. Record the incident on Activity Master List to include from whom, the date received, subject matter.

3. Immediately make contact with the consumer or PCA to clarify the concern or complaint as to the “who, what, where, when and how” and plan of action.

4. From there, and depending on the nature of the concern or complaint, assess what follow-up is required to resolve it.

5. Formalize the complaint or concern by drafting a written report and share with the staffing department (which includes staffing supervisors, senior staffing supervisor program specialist and executive director) via e-mail and save file to appropriate drive depending on the nature of the complaint or concern. The report will identify the specifics of the complaint; the follow-up that was conducted; safety mentor observations and recommendations; and its resolution.

Dignity of Risk

Purpose: The purpose of this policy is to determine the location of the Dignity of Risk form and determine when this form should be used.

Location: The form is stored at the following location: ..\Mentor Reports\Dignity of Risk - blank copy.doc

Process: This form should be used when a consumer is choosing to ignore ILS expert opinion in regards to safety or fraud prevention. This form must be signed by the consumer, Director, and Staffing Supervisor. If the consumer refuses to sign, staff will document on form "Consumer chooses not to sign" and ask the consumer to initial acknowledgement of form. Use of this form is at the discretion of Safety Mentor and Director discretion. Some examples where this form would be appropriate would be, but not limited to:

1. Consumer refuses to use telephony system.
2. Consumer refuses to follow Safety Mentor advice on transfers.
3. Consumer regularly refuses to receive emergency medical treatment.

Medicaid Fraud Letter

PURPOSE

The purpose of this Bulletin is to remind the Medical Assistance (MA) Home and Community Based-Service providers of the requirements set forth in Sections 1101.73 (relating to provider misutilization and abuse) and 1101.75 (relating to provider prohibited acts) of Title 55 Pa Code and the procedures for reporting suspected misutilization, abuse and prohibited acts.

SCOPE

This OLTL Bulletin applies to all MA Home and Community-Based Services (HCBS) Waiver service providers, including Care Management and Service Coordination Agencies, Care Managers and Service Coordinators, Fiscal/Employer Agencies, Direct Service Agencies and employees and contractors of these agencies.

DISCUSSION The OLTL is responsible for providing MA HCBS providers with information about financial abuse and program fraud; documentation requirements; how to report suspected fraud or abuse and remedies available for enforcement.

Title 55 Pa Code § 1101.73 (relating to provider misutilization and abuse) discusses the steps taken if a provider is found billing for services inconsistent with MA regulations, unnecessary, inappropriate to patients' health needs or contrary to customary standards of practice. Examples of provider misutilization and abuse include, but are not limited to, the following:

- Charging excessively for services or supplies;
- Submitting claims for services thatdo not meet CMS/MA medical necessity criteria;
- Breaching the Medicare/Medicaid participation or assignment agreements;
- Improperly submitting claims or utilizing incorrect coding; and
- Submitting incomplete records required to document service provision, or as otherwise required by state and/or federal rules.

Title 55 Pa. Code § 1101.75 (relating to provider prohibited acts) outlines the acts prohibited under the MA program. Examples of provider prohibited acts include, but are not limited to, the following:

- Submitting claims for services or supplies that were not provided;
- Altering claims to obtain higher payments;

- Soliciting, offering or receiving a kickback, bribe or rebate (for example, paying for referral of clients);
- Completing Certificates of Medical Necessity (CMNs) for patients not known to the provider;
- Submitting any false data on claims, such as the date of service, units of service, or the provider of service; and
- Using deceptive enrollment practices.

The following are situational examples of program fraud committed by providers:

- A personal care worker continued to bill and be paid for services authorized under an MA waiver while the individual supposed to be receiving the services was incarcerated. Both the worker and the person supposed to be receiving the services conspired to continue billing for the services in order to gather money for bail.
- A personal care worker billed and received payment for hours of service provided to an individual needing assistance while the personal care worker was on duty at another job.

Examples of program fraud committed by individuals receiving services:

- Using another person's Medicare/Medicaid card to obtain medical care; and
- Signing an attendant's timesheet for hours of care not provided.

Documentation Requirements for Services Rendered Title 55 Pa. Code § 1101.51 (d) establishes standards of practice and § 1101.51 (e) sets forth record keeping requirements for all provider types, including MA HCBS Waiver providers. The OLTL must assure that providers have sufficient and accurate documentation to support claims submitted for payment. This documentation is used by the Department to determine the validity of claims submitted, the medical necessity and quality of services provided to MA recipients.

PROCEDURES

Providers should review their record keeping practices to ensure compliance with applicable Federal and State statutes and regulations, as well as compliance with their licensing and approval standards.

Reporting Providers that detect or suspect a prohibited act has been committed MUST report the suspected prohibited act to the DPW Office of Administration, Bureau of Program Integrity. This DOES NOT preclude reporting to any other investigative agency or entity.

Detected or suspected prohibited acts must be reported immediately to the Bureau of Program Integrity (BPI) through one of the methods listed below.

- By electronically submitting the MA Provider Compliance Hotline Response Form (http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/maprovidercomplianceh otlineresponseform/index.htm)
- By phone: 1-866-DPW-TIPS (1-866-379-8477)

- By fax: (717) 772-4655-Attention: MA Provider Compliance Hotline
- By U.S. Mail:

Bureau of Program
Integrity MA Provider
Compliance Hotline P.O.
Box 2675 Harrisburg, PA
17105-2675

Remedies for Enforcement OLTL reminds providers that DPW has the following enforcement actions listed in 55 Pa. Code § 1101.77 (relating to enforcement actions taken by the Department) available to address fraud and financial abuse. These actions include terminating the provider's provider enrollment and participation in the MA program.

Providers convicted of prohibited acts are subject to criminal penalties outlined in 55 Pa. Code § 1101.76 (relating to criminal penalties).

Providers who have engaged in prohibited acts can also be referred to federal authorities for further investigation and possible prosecution, according to 55 Pa. Code § 1101.74 (relating to Provider fraud).

DPW can also seek restitution and reimbursement for payments made for prohibited acts under 55 Pa Code § 1101.83 (relating to restitution and repayment).

CHAPTER NINE

HALO

Time and Attendance

DCW Task Sheets

New Participants

Participant Changes

Closing Participants

New DCW

Entering a new DCW into Halo

To open a DCWs home screen, select Agency Employee, then click the " Select an Aide to Edit" drop down box. Type in the DCWs name (last, first) to select their record.

New DCWs will have their primary information (address, primary phone, date of birth) entered in fields that have a blue background. You must use an employee change form to notify HR of any changes to this information and HR will update this part of the record.

When assigned a new DCW to supervise, you must enter the following information on their Agency Employee page in Halo:

- Your name as the Staffing Coordinator
- A second phone number (mobile) if they have one
- The Zone they live in
- Make sure Status is a "3" for Active.
- Make sure "Mailbox Open Y/N" is changed to "Y" which enables phone logging
- For "Caller Type" choose "Aide – schedule" from the dropdown menu.
- Employee Type: Agency
- Available Days: Select the days they are available to work
- Total Hours: enter the number of hours they would like to be scheduled
- Zones: enter the zones they are willing to work in
- Specialized skills: note any specialized training or skills (example: CNA)
- General information: other information pertinent to scheduling this aide

If the DCW has certain days that they are never available, enter this into their Master Service Plan so that they aren't called to work or cover fill-ins on these days: Main Menu / Personnel Menu / Master Service Plan / Choose "Select the Aide" dropdown menu, type in aides name (last, first) to select aide' s MSP and add "Attendant, Not Available" for the applicable days.

DCW Termination

When a DCW is no longer employed by AI ILS, either by resignation or termination, their staffing supervisor must turn off their access to the Halo mailbox (thus ending their ability to log in or out) and change their status from "3" active to either "8" left company or "9" terminated. All their assigned shifts must also be changed in the participants MSP to "Hours, Open" and dated as of the day after their last day of employment, so that these shifts can be assigned to other DCWs.

An Employee Change form must also be filled out and sent to HR along with all documentation around the separation from employment. This form is located in: Staffing/forms/change forms/blank change form.

Scheduling MSP New/Ending/Changing

Kickouts

Over/Under Authorized Hours report by Participant

Error logs

Overlap reports

This report lists logging errors in Halo which have a DCW logged in at 2 places at once, or a participant with more than one aide logged in at their home at the same time. This report is run prior to billing and payroll. If errors are found, go into the verified visits menu to make any necessary corrections.

Personnel Menu/Client information/add-ins/reports/Overlap Queries

- Enter dates for the pay period being reviewed.
- Model type: choose "Agency" from the dropdown menu
- Run the report twice
    - Overlapping Visits to Same Consumer
    - Overlapping Visits by Same Attendant

Verified Visits by DCW

Halo Messages

This is a feature that allows you to leave messages for DCWs that they will hear when logging into or out of Halo from a participant's home. To leave a message:

- Dial 1-877-216-5231
- Hit "#" after the time is given
- Enter the passcode 9988 to access the messaging function
- Choose "1" if you want to leave a message for up to 3 DCWs or "2" if you want to broadcast a message to all DCWs.
- Record your message at the tone and then hit "#".
- Enter the logging ID for up to 3 DCWs
- Enter "2" when you are done so that the message gets delivered

Open Hours Report

This is a function that uses Halo to find and list all shifts that need to be staffed during a specified time frame. Shifts that are open because a DCW needs the day off are preceded with an asterisk, denoting this is a single open shift that needs someone to provide fill-in coverage. Shifts without an asterisk denote shifts that do not yet have a DCW assigned. This report is accessed outside of the Halo system. IT will add an Open Shifts icon to your desktop and the report can be launched from there.

CHAPTER TEN

Billing and Payment Policies

ILS contracts out our billing and payment process to Non-Profit Management Solutions. Their policies adhere to all of the following rules and regulations.

Billing and Payment Procedure

Accessing Independence will follow the following rules and regulations:

§ 52.42. Payment policies

(a) Services will be paid as either a fee schedule service under § 52.45 (relating to fee schedule rates) or as a vendor good or service payment under § 52.51 (relating to vendor good or service payment).

(b) The Department will publish services specific to each waiver and the Act 150 program as a notice in the *Pennsylvania Bulletin*.

(c) The Department will only pay for a service in accordance with this chapter and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies).

(d) The Department will only pay for a service in the type, scope, amount, duration and frequency as specified on the participant's service plan as approved by the Department.

(e) A provider who accepts supplementary payment for an Act 150 service from a source other than the Department shall return the Act 150 payment to the Department. If the supplementary payment pays only a portion of the cost of the Act 150 service, the provider shall return an amount equal to the supplementary payment to the Department. This subsection does not apply to copayments.

(f) The Department will recoup payments which are not made in accordance with this chapter.

(g) The Department may limit the type of service available in accordance with Federal and State laws, the waiver program requirements or Act 150 program requirements.

(h) The Department will not reimburse a provider who renders a service to a participant who does not have an approved service plan for the date when the service was rendered.

(i) To be paid the MA Program fee schedule rate or receive reimbursement for a vendor good or service, a provider shall comply with this chapter.

(j) The Department will not pay for a service which is rendered to a participant who is enrolled in a waiver or the Act 150 program that does not include the service.

§ 1101.63. Payment in full.

(a) *Supplementary payment for a compensable service.* A provider shall accept as payment in full, the amounts paid by the Department plus a copayment required to be paid by a recipient under subsection (b). A provider who seeks or accepts supplementary payment of another kind from the Department, the recipient or another person for a compensable service or item is required to return the supplementary payment. A provider may bill a MA recipient for a noncompensable service or item if the recipient is told before the service is rendered that the program does not cover it.

(b) *Copayments for MA services.*

(1) Recipients receiving services under the MA Program are responsible to pay the provider the applicable copayment amounts set forth in this subsection.

(2) The following services are excluded from the copayment requirement for all categories of recipients:

(i) Services furnished to individuals under 18 years of age.

(ii) Services and items furnished to pregnant women, which include services during the postpartum period.

(iii) Services furnished to an individual who is a patient in a long term care facility, an intermediate care facility for the mentally retarded or other related conditions, as defined in 42 CFR 435.1009 (relating to definitions relating to institutional status) or other medical institution if the individual is required as a condition of receiving services in the institution, to spend all but a minimal amount of his income for medical care costs.

(iv) Services provided to individuals residing in personal care homes and domiciliary care homes.

(v) Services provided to individuals eligible for benefits under the Breast and Cervical Cancer Prevention and Treatment Program.

(vi) Services provided to individuals eligible for benefits under Title IV-B Foster Care and Title IV-E Foster Care and Adoption Assistance.

(vii) Services provided in an emergency situation as defined in § 1101.21 (relating to definitions).

(viii) Laboratory services.

(ix) The professional component of diagnostic radiology, nuclear medicine, radiation therapy and medical diagnostic services, when the professional component is billed separately from the technical component.

(x) Family planning services and supplies.

(xi) Home health agency services.

(xii) Services provided to individuals receiving hospice care.

(xiii) Psychiatric partial hospitalization program services.

(xiv) Services furnished by a funeral director.

(xv) Renal dialysis services.

(xvi) Blood and blood products.

(xvii) Oxygen.

(xviii) Ostomy supplies.

(xix) Rental of durable medical equipment.

(xx) Targeted case management services.

(xxi) Tobacco cessation counseling services.

(xxii) Outpatient services when the MA fee is under $2.

(xxiii) Medical examinations when requested by the Department.

(xxiv) Screenings provided under the EPSDT Program.

(xxv) More than one of a series of a specific allergy test provided in a 24-hour period.

(3) The following services are excluded from the copayment requirement for categories of recipients except GA recipients age 21 to 65:

(i) Drugs, including immunizations, dispensed by a physician.

(ii) Specific drugs identified by the Department in the following categories:

(A) Antihypertensive agents.

(B) Antidiabetic agents.

(C) Anticonvulsants.

(D) Cardiovascular preparations.

(E) Antipsychotic agents, except those that are also schedule C-IV antianxiety agents.

(F) Antineoplastic agents.

(G) Antiglaucoma drugs.

(H) Antiparkinson drugs.

(I) Drugs whose only approved indication is the treatment of acquired immunodeficiency syndrome (AIDS).

(4) Except for the exclusions specified in paragraphs (2) and (3), each MA service furnished by a provider to an eligible recipient is subject to copayment requirements.

(5) The amount of the copayment, which is to be paid to providers by categories of recipients, except GA recipients, and which is deducted from the Commonwealth's MA fee to providers for each service, is as follows:

(i) For pharmacy services, drugs and over-the-counter medications:

(A) For recipients other than State Blind Pension recipients, $1 per prescription and $1 per refill for generic drugs.

(B) For recipients other than State Blind Pension recipients, $3 per prescription and $3 per refill for brand name drugs.

(C) For State Blind Pension recipients, $1 per prescription and $1 per refill for brand name drugs and generic drugs.

(ii) For inpatient hospital services, provided in a general hospital, rehabilitation hospital or private psychiatric hospital, the copayment is $3 per covered day of inpatient care, to an amount not to exceed $21 per admission.

(iii) For nonemergency services provided in a hospital emergency room, the copayment on the hospital support component is double the amount shown in subparagraph (vi), if an approved

waiver exists from the United States Department of Health and Human Services. If an approved waiver does not exist, the copayment will follow the schedule shown in subparagraph (vi).

(iv) When the total component or only the technical component of the following services are billed, the copayment is $1:

(A) Diagnostic radiology.

(B) Nuclear medicine.

(C) Radiation therapy.

(D) Medical diagnostic services.

(v) For outpatient psychotherapy services, the copayment is 50¢ per unit of service.

(vi) For all other services, the amount of the copayment is based on the MA fee for the service, using the following schedule:

(A) If the MA fee is $2 through $10, the copayment is 65¢.

(B) If the MA fee is $10.01 through $25, the copayment is $1.30.

(C) If the MA fee is $25.01 through $50, the copayment is $2.55.

(D) If the MA fee is $50.01 or more, the copayment is $3.80.

(E) The Department may, by publication of a notice in the *Pennsylvania Bulletin*, adjust these copayment amounts based on the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(6) The amount of the copayment, which is to be paid to providers by GA recipients age 21 to 65, and which is deducted from the Commonwealth's MA fee to providers for each service, is as follows:

(i) For prescription drugs:

(A) $1 per prescription and $1 per refill for generic drugs.

(B) $3 per prescription and $3 per refill for brand name drugs.

(ii) For inpatient hospital services, provided in a general hospital, rehabilitation hospital or private psychiatric hospital, the copayment is $6 per covered day of inpatient care, not to exceed $42 per admission.

(iii) When the total component or only the technical component of the following services are billed, the copayment is $2:

(A) Diagnostic radiology.

(B) Nuclear medicine.

(C) Radiation therapy.

(D) Medical diagnostic services.

(iv) For all other services, the amount of the copayment is based on the MA fee for the service, using the following schedule:

(A) If the MA fee is $2 through $10, the copayment is $1.30.

(B) If the MA fee is $10.01 through $25, the copayment is $2.60.

(C) If the MA fee is $25.01 through $50, the copayment is $5.10.

(D) If the MA fee is $50.01 or more, the copayment is $7.60.

(E) The Department may, by publication of a notice in the *Pennsylvania Bulletin*, adjust these copayment amounts based on the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(7) A provider participating in the program may not deny covered care or services to an eligible MA recipient because of the recipient's inability to pay the copayment amount. This paragraph does not change the fact that the recipient is liable for the copayment, and it does not prevent the provider from attempting to collect the copayment amount. If a recipient believes that a provider has charged the recipient incorrectly, the recipient shall continue to pay copayments charged by that provider until the Department determines whether the copayment charges are correct.

(8) A provider may not waive the copayment requirement or compensate the recipient for the copayment amount.

(9) If a recipient is covered by a third-party resource and the provider is eligible for an additional payment from MA, the copayment required of the recipient may not exceed the amount of the MA payment for the item or service.

(c) *MA deductible.*

(1) A $150 deductible per fiscal year shall be applied to adult GA recipients for the following MA compensable services:

(i) Ambulatory surgical center services.

(ii) Inpatient hospital services.

(iii) Outpatient hospital services.

(2) Laboratory and X-ray services are excluded from the deductible requirement.

Authority

The provisions of this § 1101.63 amended under sections 201(2), 403(b), 403.1, 443.1, 443.3, 443.6, 448 and 454 of the Public Welfare Code (62 P. S. § § 201(2), 403(b), 403.1, 443.1, 443.3, 443.6, 448 and 454).

§ 1101.75. Provider prohibited acts.

(a) An enrolled provider may not, either directly or indirectly, do any of the following acts:

(1) Knowingly or intentionally present for allowance or payment a false or fraudulent claim or cost report for furnishing services or merchandise under MA, knowingly present for allowance or payment a claim or cost report for medically unnecessary services or merchandise under MA, or knowingly submit false information, for the purpose of obtaining greater compensation than that to which the provider is legally entitled for furnishing services or merchandise under MA.

(2) Knowingly submit false information to obtain authorization to furnish services or items under MA.

(3) Solicit, receive, offer or pay a remuneration, including a kickback, bribe or rebate, directly or indirectly, in cash or in kind, from or to a person in connection with furnishing of services or items or referral of a recipient for services and items.

(4) Submit a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source.

(5) Submit a claim for services or items which were not rendered by the provider or were not rendered to a recipient.

(6) Submit a claim for services or items which includes costs or charges which are not related to the cost of the services or items.

(7) Submit a claim or refer a recipient to another provider by referral, order or prescription, for services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are not medically necessary.

(8) Submit a claim which misrepresents the description of the services, supplies or equipment dispensed or provided, the date of service, the identity of the recipient or of the attending, prescribing, referring or actual provider.

(9) Submit a claim for a service or item at a fee that is greater than the provider's charge to the general public.

(10) Except in emergency situations, dispense, render or provide a service or item without a practitioner's written order and the consent of the recipient or submit a claim for a service or item which was dispensed or provided without the consent of the recipient.

(11) Except in emergency situations, dispense, render or provide a service or item to a patient claiming to be a recipient without first making a reasonable effort to verify by a current Medical Services Eligibility card that the patient is an eligible recipient with no other medical resources.

(12) Enter into an agreement, combination or conspiracy to obtain or aid another in obtaining payment from the Department for which the provider or other person is not entitled, that is, eligible.

(13) Make a false statement in the application for enrollment or reenrollment in the program.

(14) Commit a prohibited act specified in § 1102.81(a) (relating to prohibited acts of a shared health facility and providers practicing in the shared health facility).

(b) A provider or person who commits a prohibited act specified in subsection (a), except paragraph (11), is subject to the penalties specified in § § 1101.76, 1101.77 and 1101.83 (relating to criminal

penalties; enforcement actions by the Department; and restitution and repayment).

Authority

The provisions of this § 1101.75 issued under sections 403(a) and (b), 441.1 and 1410 of the Public Welfare Code (62 P. S. § § 403(a) and (b), 441.1 and 1410).

CHAPTER ELEVEN

Department of Health Chapter Consumer Protections

§ 611.57. Consumer protections.

(a) *Consumer rights*. The consumer of home care services provided by a home care agency or through a home care registry shall have the following rights:

(1) To be involved in the service planning process and to receive services with reasonable accommodation of individual needs and preferences, except where the health and safety of the direct care worker is at risk.

(2) To receive at least 10 calendar days advance written notice of the intent of the home care agency or home care registry to terminate services. Less than 10 days advance written notice may be provided in the event the consumer has failed to pay for services, despite notice, and the consumer is more than 14 days in arrears, or if the health and welfare of the direct care worker is at risk.

(b) *Prohibitions*. No individual as a result of the individual's affiliation with a home care agency or home care registry may assume power of attorney or guardianship over a consumer utilizing the services of that home care agency or home care registry. The home care agency or home care registry may not require a consumer to endorse checks over to the home care agency or home care registry.

(c) *Information to be provided*. Prior to the commencement of services, the home care agency or home care registry shall provide to the consumer, the consumer's legal representative or responsible family member an information packet containing the following information in a form that is easily read and understood:

(1) A listing of the available home care services that will be provided to the consumer by the direct care worker and the identity of the direct care worker who will provide the services.

(2) The hours when those services will be provided.

(3) Fees and total costs for those services on an hourly or weekly basis.

(4) Who to contact at the Department for information about licensure requirements for a home care agency or home care registry and for compliance information about a particular home care agency or home care registry.

(5) The Department's complaint Hot Line (1-866-826-3644) and the telephone number of the Ombudsman Program located with the local Area Agency on Aging (AAA).

(6) The hiring and competency requirements applicable to direct care workers employed by the home care agency or referred by the home care registry.

(7) A disclosure, in a format to be published by the Department in the *Pennsylvania Bulletin* by February 10, 2010, addressing the employee or independent contractor status of the direct care worker providing services to the consumer, and the resultant respective tax and insurance obligations and other responsibilities of the consumer and the home care agency or home care registry.

(d) *Documentation*. The home care agency or home care registry shall maintain documentation on file at the agency or registry of compliance with the requirements of this section which shall be available for Department inspection.

CHAPTER TWELVE

Chapter 55 Regulation Compliance Policy

Accessing Independence will follow the following rules and regulations:

Medicaid Home and Community Based Services (HCBS) Waiver Program as authorized by the §1915(c) of the Social Security Act for the Attendant Care, Independence, OBRA, Aging, Commcare Waivers and Act 150.

55 PA. Code Chapter 52 Long Term Living Home and Community Based Services

55 PA. Code Chapter 1101 general provisions for Pennsylvania Medical Assistance

28 PA. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries).

All AI staff are trained on and are required to follow all current Pennsylvania Bulletins and directives from the Office of Long Term Living that relate to the Home and Community Based Services Programs. AI staff will be trained on any new bulletins, directives and regulations as they are issued DPW and the Office of Long Term Living.

PA Department of Welfare HCBS Chapter 52 Regulations

OLTL Chapter 52 Regulations FAQ

June 25, 2013

	FINAL OLTL FAQs - 55 Pa. Code Chapter 52 - 6/17/2013	
#	**Question**	**Answer**
	Enrollment - Provider and Consumer	
1	The regulations state that services can't start unless there is an OLTL approved service plan in place. Does this apply when there is a delay in approval by OLTL because of technical/IT problems or the Commonwealth is behind in reviews?	No. If the delay is due solely to occasional technical difficulties or backlogs in review of service plans by OLTL, services to consumers must continue while these difficulties are resolved. However, payment will NOT be made for services rendered to someone who is not enrolled in a waiver or who does not have initial approval of their service plan.
2	Are the following approved OLTL forms still to be used: a.) PA Office of Long-Term Living Criminal History Background Check b.)Participant Verification of Acceptance of Responsibility c.)OLTL Provider Choice Protocol d.)OLTL-BIS Service Provider Choice Form e.) Freedom of Choice Form f.) Selection of AC Control Option	Out of the list of forms in question, the following forms are to be used: c. Provider Choice Protocol is to be followed d. OLTL-BIS Service Provider Choice Form e. Freedom of Choice Form The remaining forms are obsolete.

3	Is the CMI completed by the enrollment agency or the service coordination agency? Is there a checklist of information and/or forms that need to be sent to the SCE by the IEB? Is the referral to a SCE still part of enrollment?	Certain sections of the CMI are prepopulated from the LOCA by the AAA and the IEB completes certain sections of the CMI at the time of enrollment. The SC is responsible to complete the unfinished sections of the CMI at the initial service plan development meeting, and is completed by the SC at the time of annual reassessment. Yes, the checklist is the LOCA, physician certification, CMI, Freedom of Choice Form and the PA 162. Yes, the referral to a SCE is part of enrollment.
4	How does the AAA bill for a successful enrollment when the consumer chooses the LIFE program and there is no successful enrollment into the Aging Waiver?	There would be no payment. Successful enrollment pertains to Aging Waiver activities.
4A	How is "successful" enrollment defined?	A successful enrollment is defined as a referral to the Aging Waiver in which the AAA completes all necessary steps to submit the application for enrollment. Necessary steps include facilitating the process of obtaining a physician certification form, completion of a LOCA and CMI, and MA eligibility. The applicant must be found eligible, both clinically and financially for the waiver.
4B	a.) If an Aging Waiver participant goes into the nursing facility for more than 30 days and must be closed from the waiver, are we paid for their enrollment when they are discharged from the nursing facility? b.) Is there a limit on how often this can happen? c.) What is the procedure now? Must this consumer complete a new PA 600 or do we continue to send the PA 1768? d.) What part will be care enrollment?) C i i h h h ill h h ite.) Can we resume prior services when the consumer comes home or will they have to wait on the CAO approval?	a.) Please refer to the Maintaining Waiver Eligibility While in an Institution bulletin (05-12-02, 51-1202, 52-12-02, 55-12-02, 59-12-02) issued January 24, 2013. The timeframe was extended to 180 days. b.) Payment for a new enrollment is permitted only once in a calendar year. c.) There is no need to complete a new PA600 unless there is a change in the person's financial situation. d.) None, if the participant is in the facility for less than 180 days.)P i i l h i i ' d h h de.) Prior services can resume - unless the participant's needs have changed.
4C	Can you please clarify, when a participant transfers from Options to Waiver what start date should we be utilizing to be reimbursed for both enrollment and service coordination.	This scenario is no different than a regular enrollment - the same procedures for enrollment should be used. The start date is the date that OLTL approves the ISP.
5	What constitutes "enrollment paperwork"? What if anything will be sent to the SC provider via hardcopy/mail? (outside of SAMS for Aging Waiver participants)	Enrollment paperwork consists of a copy of the PA 162, the physician certification, and the Freedom of Choice form. For the Aging Waiver, the LOCA and CMI are located in SAMS for the receiving SCE.
5A	The AAA will do the enrollment for the Aging Waiver. The SC training refers to an Enrollment form to be sent to the SCE. Is that form available?	There is no separate form titled "Enrollment Form"; send the PA 162, physician certification, and freedom of choice form.
6	If an agency needs to make a request to the Department of Health (DOH) to move the Home Care license from one agency to another, will OLTL cite them if they have documentation in their file that they requested the moving of the license but haven't yet had a response from DOH? OR, will OLTL not allow them to provide service until DOH either moves this license or issues a new one?	OLTL will not cite an agency in this scenario as long as the request is in the file and there is reasonableness in the length of time from the request to the review. There should also be documentation of requests to DOH for the transfer if lengthy periods have elapsed between the original request and the review.
7	Is the Conflict Free Service Coordination Choice Form the only enrollment requirement that has to be completed by the AAAs? Are there any other enrollment requirements if the agency has only had the administrative care management program through a contract?	The Conflict Free Service Coordination Choice Form is for any agency, including Area Agencies on Aging (AAAs), that desires to become or are currently a Service Coordination Entity (SCE). Please contact the Bureau of Provider Support (BPS) at 1-800-932-0939 for any additional paper requirements.
8	What process will be utilized by service coordination agencies to indicate what population should be served? Will there be requirements to serve waiver "populations"?	Entities should contact the Bureau of Provider Support (BPS) at 1-800-932-0939 for instructions and requirements on enrollment.
9	If a county has only one home delivered meal provider serving Aging Waiver participants, and the provider is the parent agency, how can that provider comply with the conflict free regulation?	As an Organized Health Care Delivery System (OHCDS) provider, the agency is able to maintain the home delivered meal service.

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#	**Question**	**Answer**

9A	How does and agency find out if it is still an Organized Healthcare Delivery System Provider to provide Meals or Home Mods for our Aging Waiver Consumers?	Contact the Bureau of Provider Support (BPS) at 1-800-932-0939 for any questions related to provider status.
10	Where can the rules and regulations be found for Procedural Code W1793, Personal Assistance Services (Agency Model) and the requirements that are required to hire employees, maintain cases, etc.?	Providers should refer to the applicable waiver for requirements for agency model of services. The waivers can be found at: **http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733116&mode=2**. Any further question should be directed to the Bureau of Provider Support (BPS) at 1-800-932-0939. In addition, requirements can be found in the PA Department of Health (DOH) Home Care Regulations.
11	For AAAs who wish to enroll as service coordination entities, what process occurs to indicate the region they wish to serve?	AAAs should contact the Bureau of Provider Support (BPS) at 1-800-932-0939 for instructions on enrollment.
12	Is the two step tuberculosis (TB) immunization required upon hire and the one step TB immunization to be done annually?	TB immunization requirements are in the PA Department of Health (DOH) Home Care regulations. Please refer to them or contact your County Health Department for additional information.
13	How will the data reporting changes be handled: HCSIS for AAAs and SAMS for the under 60 waiver providers?	Instructions and training will be provided to those agencies as they enroll to provide services to new specific populations.
14	In regard to the enrollment rate, reimbursement is for "successful" enrollments only. Did the rate methodology take into account staff time that it takes attempting to enroll a consumer who, subsequently, is determined to not be eligible for the Aging Waiver?	For updated enrollment rate for AAAs please refer to **http://www.pabulletin.com/secure/data/vol43/43-4/146.html,** and the Billing Instructions Bulletin **(0513-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** issued on February 7, 2013. The Billing Instructions Bulletin may be found at the following link: **http://www.portal.state.pa.us/portal/server.pt/community/bulletins/19451**.
15	Where can we find the crosswalk OLTL BPS Provider Specialty Code to the Aging Waiver procedure codes? If OLTL certifies a provider as a Type 05 Home Health Provider using Specialty Code 050 Home Health Agency: (a) Should we be entering that provider into SAMS Admin for every Aging Waiver procedure code for each skilled care service? (b) Must they be separately approved for W1793 PAS Agency Model? (c) We enter DPW Specialty Code 362 as Provider Service W1793 in SAMS Admin. Does Specialty Code 361 also become W1793?	The crosswalk can be found with the Billing Instructions Bulletin referenced above. a.) Yes. b.) Yes, AAAs are to enter the provider into the admin tables in SAMS based on the approved information received from OLTL. c.)OLTL – not AAAs – is responsible for assigning provider type specialty codes in PROMISe and SAMS. AAAs should not assign or add any provider codes or provider specialty codes.
16	Where would I find the paperwork that goes with the Act 150 program? We also are in need of information on how we work with HCSIS for these under 60 consumers.	The Act 150 program utilizes the same policies, procedures and forms as the Attendant Care Waiver. Contact BPS at 1-800-932-0939 for new provider training and HCSIS access.
17	If a current Aging Waiver participant informs the SC entity that they are planning to relocate to another county, what would be the process to transfer them to the receiving county, i.e. enrollment and choice of service coordination entity serving that county?	There is no new enrollment needed. It is the SC entity's responsibility to provide the relocating participant with an SC entity list for the new county, to provide choice of providers to the participant and to coordinate the transfer with the participant's new service coordinator.
18	In cases where service coordination is being done by both counties to coordinate a cross county transition how should these billing dates occur?	A transfer date should be agreed upon by both entities. Any service coordination performed before the transfer date is billed to the old location; any service coordination performed after the transfer date is billed to the new location.
18A	When we are dealing with waiver transfers from one county to another, can we have some clarification and training across the AAAs and CAOs regarding how the PA 1768s are being completed?	Service coordination agencies should simply use the "Change of County Residence" block on the PA 1768 form. The current SC must send the PA 1768 form to the CAO and to the new SC entity.
18B	When should the enrolling agencies start offering choice of SCEs and when will an updated freedom of choice form be available to reflect that Aging Waiver participants now have a choice?	The enrolling agency should provide choice upon completion of enrollment. An updated choice form is forthcoming.
19	Prior to June 30, we had been using one of the grant funded home modification contractors through Home Modification Construction Officers (HMCOs) to evaluate for home modifications and obtain estimates for home modifications. HMCOs would then provide the home modification through the contractor. Do you have any suggestions for how we can obtain these home modifications moving forward?	There have been no changes to this process.

20	How does separation of enrollment and SC for "conflict free" SC affect NHT?	Service Coordination Entities are permitted to continue as an OLTL recognized Nursing Home Transition partner.
21	To enroll as a PAS provider for waiver, do you have to provide all three services of personal care, personal assistance, and home support?	Personal Care and Home Support are no longer discrete services in the Aging Waiver, but have been incorporated into the Personal Assistance service definition. If an agency enrolls to provide Personal Assistance Services, they are expected to provide all components of the service definition as outlined in the participant's service plan.

	FINAL OLTL FAQs - 55 Pa. Code Chapter 52 - 6/17/2013	
#	**Question**	**Answer**
	Conflict Free Service Coordination	
1	In regards to conflict free service coordination, should agencies send a notification of eligibility to consumers for the services they decide not to provide?	55 PA Code Chapter 52 §52.61 outlines what actions must be taken by providers who plan to cease providing a service. The provisions of that section do not require that a notification of eligibility form be sent.
2	Can a provider split and start new corporations, one for service coordination and one for direct services?	Providers are required to follow 55 PA Code Chapter 52, including § 52.28 which addresses the requirements providers must meet to ensure that the agency is conflict free.
	Qualifications for Service Coordination	
1	If staff does not meet the service coordinator qualifications, should their employment be terminated?	Under 55 PA Code, the Home and Community-Based Services (HCBS) regulation does not provide for grandfathering of service coordinators. However, for employees hired prior to the regulation being in place, OLTL will review requests by agency directors on a case-by-case basis, and OLTL will work with them to bring their staff into compliance. Please send written requests to: RA-HCBS-REG@pa.gov.
2	What are DPW's plans for training the new service coordination agencies, AAAs and others?	Ongoing SC training began in March 2012 and new provider training is scheduled quarterly on an ongoing basis. A schedule of new provider training dates can be requested from the Bureau of Provider Support at 1-800-932-0939 . There are also several resources on the Long Term Living Training Institute's website at http://www.ltltrainingpa.org
3	Is a licensed RN that meets the training and experience requirements, recognized as meeting the requirements for supervision of service coordination?	Anyone who meets the requirements for service coordination supervisor may be hired in this supervisory position.
4	Is it possible for a staff member who has been entering service orders for many years, who does not have the requisite college credits, to have an exemption from the qualifications? Nothing else is being done other than entering them into the computer – it is purely data entry.	No. Data entry by anyone other than the SC may not be billed for under Service Coordination. Only if the service coordinator enters data is it considered to be a component of service coordination.
	Service Coordination	
1	Are RN's required and have they ever been required? Does the RN need to review and sign off on the LOCAs and CMIs once Service Coordination is implemented July 1st? How is that to be implemented?	There has been no change in policy on these matters. RNs are required to sign Level of Care Assessments. Only in limited cases where a participant has complex medical needs, or if they request it, must an RN sign the CMI (see Aging Waiver, Appendix D, at **http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733693&mode=2**).

1A	Does a homecare agency need to have a nurse to do the supervisory visit every 90 days?	The OLTL waivers do not stipulate that Personal Assistance Services agencies must have a nurse conduct a supervisory visit every 90 days. However, please check the Department of Health licensing requirements and Medicare requirements for your agency.
2	Can the service coordination entity (SCE) provide FMS for COMMCARE consumers under the new HCBS regulation? Does 55 Pa. Code Chapter 52 supersede the COMMCARE Waiver standards?	No. Effective January 1, 2013 an SCE may not provide FMS for COMMCARE consumers or those in any other OLTL waivers. Yes, 55 PA Code Chapter 52 supersedes the COMMCARE waiver all standards.
3	If an RN home visit is not a component of service coordination, does this mean that the RN does not have to visit the consumer during the year unless it is documented that a visit is required and justification is provided to implement it as a formal support?	An RN does not have to visit a consumer during the year. Ongoing skilled nursing care must be provided as a distinct waiver service if there is a documented need.
3A	If it is documented that an RN must visit the consumer, how do we receive reimbursement for this? Is there an "enhanced" SC rate to allow for the additional cost?	RN home visits are services that, if based on the documented assessed need, would be added to the service plan as a discrete service. There is no enhanced SC rate.
4	Do we still enter a service delivery of Assessment, LOCA (Annual Recertification) since the time to do the LOCA will now be a billable service under Service Coordination? If we do not enter the Assessment, does this affect reports being run for compliance purposes?	Conducting the LOCA is NOT a billable service under service coordination. It is a separate function paid for by Title XIX. There is no change in how LOCAs are documented in SAMS.
5	When we help the consumer complete their annual recertifications for DPW to determine their continued financial eligibility, is that billable for service coordination? Why is conducting Medicaid financial eligibility determinations or redeterminations considered as non-billable; particularly the redeterminations?	Assisting in collection of participant-required information, including assisting the participant with the MA application, contacting the CAO, assisting with the appeals process if necessary, etc., is billable for service coordination. Financial eligibility determination or redetermination can only be conducted by the CAO and therefore cannot be billed under Service Coordination.

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#	**Question**	**Answer**
6	(a) If consumers continue to refuse to have personal care (PC) tasks completed, do AAAs terminate them from the waiver? (b) If so, is termination appealable? (c) Do they need to give advance notice?	(a) Yes. Waiver services cannot be provided if an individual refuses the minimum services that are requisite for enrollment in a waiver. In such a case, the service coordinator may choose to pursue other funding mechanisms to support the individual. (b) Yes. (c) Yes.
7	Can PAS Agency aides transport consumers to medical and non-medical visits without the same restrictions placed on transportation by personal care aides?	When PAS is provided through an agency, the agency makes the determination whether they will allow their employees to provide transportation to participants. When the participant is the employer of the PAS worker, the PAS worker can provide transportation for the participant. However, the PAS worker cannot be paid for both hours worked and mileage.
8	What is the process for requesting approval of additional service coordination hours?	**See page 4** of the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)**, issued on February 7, 2013 which contains information on the process: The Billing Instructions Bulletin may be found at the following link: **http://www.portal.state.pa.us/portal/server.pt/community/bulletins/19451**.
8A	As long as you stay under 144 units a year, can you exceed 12 units per month?	Yes. The 144 units is a yearly, flexible limitation. Service Coordinators may see increased and decreased service coordination needs from month to month depending on the needs of each participant.
8B	Are there recommendations on how to provide service coordination within the suggested cap?	Service coordination is provided based on the assessed needs of each individual waiver participant. For more detailed information and guidance on how to request additional units please see the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)**
8C	Will the cap be reviewed over time and changed if it is found that the hours exceed the recommended cap?	OLTL monitors utilization of all services and looks for trends across agencies as well as across the overall program. Determination of where increases or decreases are made is dependent on analysis of utilization. Also, additional units may be requested when needed in accordance with the Billing Instructions Bulletin.

8D	We have been submitting Service Plan Review Requests for additional Service Coordination to OLTL. This is not a situation where we have utilized 75% of our allocated units. These requests are due to prorating. What will future entries look like?	According to the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** requests to increase SC units should not be submitted to OLTL until 75% of the original authorized units have been used. When developing initial Individual Service Plans for participants, Aging waiver Service Coordinators should **not** be prorating, as ISPs in SAMS are developed for the 12 month plan period. HCSIS users are only to prorate units because entries are based on effective start date to the end of the fiscal year. (which may not total 12 months)
8E	Will the process for requesting additional SC units be different for individuals with Protectivep q g Services?	If, due to the involvement of PS, additional service coordination units are needed immediately, , y because the originally requested units have been depleted, additional units may be provided and requested after the fact. SCs must document the usage of all SC units.
8F	Will HCSIS allow us to decrease units after the end of the month?	In HCSIS, Service Coordination units are allocated on an annual basis. It is, therefore, unnecessary to adjust units each month.
9	If we put the service coordinator as the sub provider, the only way to enter a service delivery is to enter that particular service coordinator. Also, if we enter daily service deliveries, will there be a report which we can run so that we are able to bill?	AAAs should enter Service Allocations and Service Orders in SAMS, not service deliveries. The Service Order will upload to HCSIS. The AAA will bill PROMISe for services rendered. PROMISe will interface with HCSIS to ensure that the number of units billed do not exceed the number of Units authorized in the Service Units. The Service Orders will always show the correct amount of units delivered. Reference: Service Coordination Module and Webinar.
10	If two SCs visit a consumer at the same time due to safety concerns, can only one of the SCs bill?	Yes, only one can bill for service coordination.
11	Since Service Coordination cannot be billed until OLTL approves the start of the ISP, this places the AAA at a great disadvantage for timely billing. What is being done to address this so that the AAAs can bill for Service Coordination in a timely manner?	OLTL is working with a small workgroup of AAAs to develop a way to address this issue.
12	Since eligibility for all waiver programs is determined by Nursing Facility Clinically Eligible status, how does OLTL/BIS determine medical needs? Is a request made to have a nurse assess the client to determine medical needs which require ongoing medical management?	OLTL/BPO reviews the LOCA, CMI and service plan to determine the needs of the individual. OLTL has a physician and RNs available to review the information if there are questions or requests regarding medical needs.
13	Whose responsibility is it to recruit providers for services? In one county a behavioral health provider has stopped doing business because the rates were insufficient to meet the costs of doing business. This service is not available to consumers.	Medicaid is a free-market system; providers decide to participate based upon the established rates and potential volume of business. Service Coordinators should notify OLTL when a service is unavailable to participants due to a lack of providers of the service.
14	How are AAAs notified as to who provides Service Coordination in their planning service areas? How are AAAs notified when there are new Service Coordination agencies since offering a participant a choice of providers is part of the enrollment process?	The Bureau of Provider Supports will send a letter to a AAA when another service coordination agency has been enrolled to provide Aging Waiver service coordination in the same service area.

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#	**Question**	**Answer**
15	The Service Coordination training manual states that a AAA sends a written communication to consumers when OLTL approves a service. Is this the ISP or another form? Do we create our own form?	Every participant to be provided services must receive a copy of their approved service plan, as stated in the ISP Bulletin (issued October 20, 2010) at: **http://www.portal.state.pa.us/portal/server.pt/community/bulletins/19451**.
15A	The AAAs have two separate forms that are sent relative to notification of adverse action and the right to appeal. Is there a standard form to use statewide?	OLTL is developing a standardized form and process across all OLTL waivers for informing participants of adverse actions. The standardized form and training is forthcoming.
16	Do monthly contacts need to be scheduled in SAMS under Activities as they were required prior to the change from care management to service coordination?	Yes. Continue to schedule monthly contacts and place them in the same location as before.
17	Are AAAs required to have the Provider's attendant logs (bathing, grooming, etc) in our files from our Waiver Providers?	No. The attendant logs are not required to be kept; however, the SC is responsible for monitoring the participant's service plan.
18	Is the nurse required to review the CMI when notified the consumer has a wound? What if the CMI was already reviewed by the RN because the consumer met one of the other criteria for a nurse review?	If the consumer does not require a new CMI, then an RN review is not required. A registered nurse must be either on staff with the Service Coordination agency or be available under contract as a nursing consultant to the Service Coordination agency for instances where RN consultation may be necessary or requested.

19	Should there be a diagnosis code in the special instructions section in the service plan for service coordination?	Yes, the diagnosis code should be entered in the special instructions as best practice. Since SCs are responsible for providing direct service providers with ICD-9 codes, OLTL expects AAAs to document ICD-9 codes in SAMS. For HCSIS users, the ICD-9 code is documented on the Diagnosis Screen, in the comments section.
20	My agency provides service coordination for the Independence Waiver, and we will soon start to provide service coordination for Aging Waiver participants. We do the annual recertification for the Independence Waiver – do we perform the annual recertification for Aging participants as well?	The AAA in the participant's county of residence is responsible for recertifications for Aging Waiver participants using the LOCA.
20A	Where can we find the list of service coordination agencies in our area? How would I find out what waiver programs these providers are service coordinators for?	A list is provided in the Services and Supports Directory in Compass. OLTL will send a letter to the AAA when additional SCEs are enrolled in their area and those agencies will be added to SAMS. The Services and Supports Directory (SSD) lists all SC agencies. The link is located at: https://www.compass.state.pa.us/compass.web/EPProviderSearch/Pgm/EPWEL.aspx?prg=LTH
20B	Are we able to adjust the list to only show the agencies that serve our county or do we have to give to consumers as is?	Consumers must be shown all agencies approved in their county. An agency can offer its own county list, but it will not be generated by OLTL.
21	What is the date we should be using for the Annual Recertification date for the Waiver?	Continue to use the date of the LOCA or the MA 51 for the OBRA Waiver.
22	Who completes the Annual Recertification for the Under 60 Waivers and the LIFE program?	The SCE is responsible for completion of the annual reevaluation of the level of care for under 60 waivers. The LIFE provider completes the *LIFE Participant Annual Recertification Form* for the LIFE program.
23	What do we do if we need quick approval for additional SC units due to unexpected consumer needs, what process should we use to get the approval in a timely manner? Will those units be approved?	Please see Billing Instructions Bulletin (05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02) issued on February 7, 2013 that has detailed instructions for requesting additional SC units.
24	Is there a standardized form stating service coordinators notify participants that an RN is available?	This information will be included in the standard informational packets begin put together by OLTL for participants.
25	If there is a change of service coordinators with the AAAs, do the service plan and service orders have to be updated with the new sub provider?	Since the service coordinator must create/update the service order the last day of each month to reflect the actual number of delivered units, it would be the time to make the SC change. The service order item must be deleted in order to recreate the service order to include the correct SC. The entire service order can be deleted and recreated with the new SC. If the change occurs in the middle of the month, two service orders are required but the dates cannot overlap.
	Rates	
1	What is the process to request a rate increase for the consumers who are part of the state program?	Participants using the participant-directed model of service should contact the F/EA vendor, PPL, for information on adjustment of direct care worker wages. Their number is1-877-908-1750. In the agency model of service, rates are now standardized and there are no negotiated rates for waiver or Act 150 services.
2	Is there an update to the April 20, 2012 letter which included rate amendments that could be effective as soon as June 1?	Please see Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** issued on February 7, 2013 that reviewed the rate-setting methodology, fee schedule rates, and vendor goods and services for the Medical Assistance Aging, Attendant Care, COMMCARE, Independence and OBRA Waivers as well as the Act 150 Program.
3	What are the exact rates? What is the exact date when they will take effect for each waiver.	Please see the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** issued on February 7, 2013.

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#	**Question**	**Answer**
4	Do the rates take into consideration overhead costs?	Overhead or indirect costs are included as a component of the OLTL HCBS market-based rates. Included in indirect costs are administrative expenses such as management, office supplies and equipment, recruitment, information technology, human resources, billing, finance, accounting, legal, and other indirect costs necessary for program operations.

5	The travel between consumers for 1 or 2 hour visits in counties with rural areas cannot be accomplished with the proposed rate. "We are required by Labor & Industry to pay travel time."	OLTL's market-based rates factored in the cost of travel and non-productive time.
6	There appears to be regional disparities in the rates. Were the different needs of urban counties and those of rural counties considered in formulating the new rates?	Yes, in order to determine the regional groupings for OLTL HCBS rates, county specific wage information and population densities were obtained and utilized to evaluate the characteristic of each county looking for commonalities in geographic market cost variances.
7	Were increasing transportation issues and rising costs factored into the rates?	Both non-client time for travel and travel costs were utilized when setting the rates.
8	The new fee is lower than the service coordination currently reimbursed in PA's Mental Health (MH) system. What would indicate that the rates should be different?	The rates were developed based on a consistent definition for service coordination for all OLTL waivers. DPW's MH system has a number of targeted case management services, and each has a corresponding fee. OLTL has reviewed the MH definitions and none appear to be consistent with OLTL's service coordination definition.
9	We will have to begin to stop providing services on evenings, weekends and holidays. Are we allowed to do that?	No. As a provision of the provider agreement, OLTL waivers and the Home and Community-Based Services regulation, providers MUST provide services in the type, scope, amount, duration and frequency as indicated in the service plan and must assure for the health and safety of waiver participants. If a service plan indicates a need for services in the evening, weekend or holiday the provider MUST provide these services.
10	How was what is now considered to be non-billable time that is spent by care managers working with Aging Waiver consumers included in the rate methodology?	The market-based rate-setting methodology that was used to set the service coordination rate includes a non-client time component.
11	Are there any plans to increase the Home Delivered Meals vendor service rate? Do we have to request a rate increase? Is there a cap for the PERS rate for the installation and the monthly monitoring? Where do we find what providers can be paid for PERS?	Please refer to Attachment A of the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-1302, 59-13-02) which** contains the new procedure codes and rates. A vendor service means that the Department will pay an Organized Health Care Delivery System or provider for the actual cost of a vendor good or service listed in the rate notice **(http://www.pabulletin.com/secure/data/vol42/4223/1058.html)** when rendered to an enrolled waiver participant. The payment may not exceed the amount for similar vendor goods or services charged to the general public. See 55 PA Code § 52.51.
	Billing	
1	Should providers begin billing using the new procedure codes and rates beginning June 1, 2012, or will these billings be rejected until all the information is in the Social Assistance Management System (SAMS) for all the counties?	The new rates were effective on June 1, 2012, and loaded into SAMS on June 4, 2012, except for enrollment for the Aging Waiver and service coordination services. Please refer to the Billing Instruction Bulletin **(05-12-01, 51-12-01, 54-12-01, 55-12-01, 5912-01)** issued on February 7, 2013 for further information on enrollment and service coordination.
2	Does nursing home transition fall into the definition of "community transition"? Is nursing home transition a "service" that AAAs would have to choose to eliminate in order to provide service coordination?	Service Coordination Entities are permitted to continue as an OLTL recognized Nursing Home Transition partner.
3	What happens under the new regulations when a PCA shows up at the participant's home and the participant does not want services? Is this still billable since the PCA had to travel to the home?	No, if the service is not provided, a provider many not bill.
4	Is the intent to eliminate respite in the nursing home?	No. Nursing facility respite care is still allowed in the Aging Waiver. The nursing facility will bill PROMISe.
5	Will enrollment be a separate contract for the AAAs?	Enrollment will be included in the AAA Title XIX Medicaid Waiver Grant Agreement. AAAs will bill PROMISe for successful enrollments rather than receive the funding through their monthly allocation.
6	Do Aging Waiver Providers need to supply gloves to their direct care workers when they provide consumers with personal assistance such as toileting? Can providers bill the state for the gloves?	Providers are required to supply gloves to direct care workers. *See,* Occupational Safety and Health Standards, 29 CFR § 1910.1030(d)(3). In terms of billing the state, no, providers cannot bill ---these costs are a component of the rate.
7	What services are billable and not billable?	Please refer to the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** issued on February 7, 2013, specifically the procedure section.

	FINAL OLTL FAQs - 55 Pa. Code Chapter 52 - 6/17/2013	
#	**Question**	**Answer**
8	May smaller amounts of time for one consumer be accumulated to get one 15 minute billable unit? If so, what documentation is required?	No. Please refer to the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** issued on February 7, 2013.
8A	Can the activities for setting up services for a new participant, that are completed in a consecutive time period, be considered billable time if done consecutively and is directly related to that one participant? (e.g. 30 minutes to coordinate services)	Yes. Since these were billable activities conducted in a consecutive time period, this can be billed as 2 billable 15-minute units of service coordination. The actual beginning and ending times for work activities related to a participant need to be documented. For example, *"10:03am-10:33am: Made calls on behalf of Mary to find a PAS provider for her. Those calls included agency A, B, and C."*
8B	Regarding the number of minutes being converted into billable units, why is 7.5-29.99 all considered 1 unit in your matrix?	In this example, 7.5-29.99 is considered two billable units. To further clarify, 7.5-22.49 minutes is considered one unit. Please refer to the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 5513-02, 59-13-02)** issued on February 7, 2013.
9	Where can we find information about the waivers, including service definitions and provider requirements?	Waiver information, including service definitions and provider requirements for all OLTL waivers can be found at: **http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733116&mode=2**.
10	When does a consumer's "participant" status begin, allowing billing for the participant as an Aging Waiver consumer?	A consumer's "participant" status begins upon receipt of the PA 162 by the AAA. Billing for services should not occur until after OLTL approves the service plan.
10A	Does the above answer just apply to direct services (such as PAS, PERS, etc.) or does it also apply to billing for service coordination and enrollment?	No billing is permitted to occur until there is an MA recipient number for an individual. It applies to service coordination and enrollment as well. The services must be on the plan and authorized in order to bill.
11	Are the following services billable: Adult Day In Home Services, Ambulance Services, Medical Transportation, Music Therapy and Recreational Services?	No, none of these services are approved services in OLTL waivers and are not billable.
11A	We are no longer able to add S5185 (medication set-up by pharmacy) to our service plans. We have many consumers who use this service. What are we to do with our consumers who are currently using this service?	As of June 1, 2012, S5185 - Medication Set-up by Pharmacist is no longer a covered service in the waiver. Neither the waiver nor MA fee for service covers medication set up as a separate billable activity. Please reassess for an appropriate service to meet the need.
11A1	How does above answer affect the PDA waiver covering Philips Medication Dispensing Service? Is there anything happening to make this Philips Medication Dispensing Service allowable in the under 60 waivers?	The pharmacy exclusion will not affect the Medication Dispensing Service. It is still covered under Telerate Dispensing and Monitoring. No, this service is currently not approved for the under-60 waivers.
11B	Are interpreter Services billable?	No. Interpreter Services are not billable. Your Medicaid provider agreement and the waivers require providers to provide oral and written assistance to Limited English Proficient (LEP) persons to aid them to access and use services. Compliance with this provision is included as a component of the service rate.
12	Since our case aides and clerical staff perform some of the face-to-face visits, phone calls and SAMS functions, is case aide/clerical time billable?	No. Case aide/clerical time is not billable as service coordination. Clerical and administrative support is included as a component of the service coordination rate.
13	Would an RN home visit be billed at a separate rate? Would an RN paper review be billed at a separate rate which would reflect her/his advanced expertise?	RN paper reviews are a component of SC and is included in the rate. AAAs should not bill SC for time spent by the RN.
14	When an RN is required to sign off the CMI, how do we bill for that event? Is it allowed to be Service Coordination and can it be entered by the RN even though they do not meet the Service Coordinator requirement or can the Service Coordinator enter the review time for the RN?	The RN is a component of Service Coordination and is included in the rate. The AAA shouldn't be billing SC for time spent by the RN.
15	During a hospital admission, consumers are considered suspended. We know service providers will not and should not be able to bill during this time. Service Coordinators could be assisting with the discharge planning etc. Is this billable time or will service coordination also be suspended and activities will not be billable during this time?	Service coordination will be suspended and activities will not be billable during that time. Any services provided on the date of discharge are billable as service coordination.
16	If an Aging Waiver consumer passes away, are the activities done by the SC after the date of death billable? Can we bill if we use a date prior to date of death to be in compliance?	No, the date of service cannot be after the date of death. These types of activities are considered non-productive time and are a component of the rate for Service Coordination.

17	When we bill for service coordination, are we permitted to bill for supervision? Is Supervisor sign off of the CMI a billable SC activity?	No. Supervisory activities are non-billable and are built into the rate.
18	How does the AAA bill for the successful enrollment once the PA 162 is received, but the consumer departs from the program (i.e. passes away, enters a Nursing Facility, voluntarily withdraws) prior to receiving OLTL approval for the care plan?	The enrollment service must be authorized before billing can occur. Once this occurs and the AAA has the 162, they can bill PROMISe. Date of service cannot occur after the date of death.
19	We have formed a new non-profit organization and are unsure what tax return is needed to satisfy 55 Pa. Code 52.11(a)(3)(i). We don't have an "owner" so do we have to send in the entire board's information?	No. For new non-profit organizations ONLY, the Office of Long-Term Living is not requiring the submission of tax return under 55 Pa. Code 52.11(a)(3)(i).

	FINAL OLTL FAQs - 55 Pa. Code Chapter 52 - 6/17/2013	
#	**Question**	**Answer**
20	In your example of a 30-minute home visit, is there some other place that topics discussed need to be recorded?	The only requirement is that billable and non-billable units are documented in Journal Entries in SAMS and the Service Notes in HCSIS.
21	What if a consumer switches counties - can the new agency bill for the W0009?	No. A new enrollment is not needed.
22	Can a supervisor bill for a billable activity when he/she is covering service coordination duties for a service coordinator?	If a service coordination supervisor is qualified as a service coordinator, they can perform service coordinator duties at the service coordination rate.
23	Are we required to enter a journal entry for every billable activity?	Yes. Activities that are not documented and billed may be disallowed as the result of a monitoring/audit.
24	Initial SC activities can take 2-4 hours. When the ISP is approved by OLTL it takes the service coordinator an additional 1-2 hours to authorize services (contacting the provider, contacting the participant, updating the service plan, generating service orders, etc.). Because the participant is care managed by Options we are not able to bill for these activities. Is there a possibility we will be able to bill for the service coordination Aging Waiver provided?	This is not an allowable practice. If a person is receiving services through another funding source, waiver funds cannot be used retroactively. OLTL is working with AAAs to explore possible ways that this activity may be covered.
25	How do we bill RN services under the new billing codes?	If a waiver participant requires nursing services, this service should be included on the participant's service plan. Home Health – Nursing is a discrete service that is available in many of OLTL's waivers. Please refer to the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 5913-02)** issued on February 7, 2013 for further information on billing codes.
26	For AAAs, what are the services we can bill for under enrollment services?	Enrollment consists of the following: • Assist in securing the Physician's Script • Assist in securing financial eligibility determination • Internally coordinate completion of the LOCA (does not include actual performance of the LOCA) • Ensure that the participant's CMI has been pre-populated from the LOCA • Provide participant with choice of service coordination agencies • Send 1768 form to CAO • Upon receipt of PA 162 from CAO, submit corresponding enrollment paperwork to chosen SC agency to begin service plan development • Enter information into SAMS for enrollment Enrollment ends
27	Can you tell me if file auditing (reviewing files for accuracy and completeness) is billable or non-billable?	Those activities are considered to be supervisory activities and are, therefore, non-billable. Supervisory activities are already built into the SC rate.
28	We recently learned AAAs receive their assessment allocation based on the total number of assessments completed x $226. The RNs cannot bill for reviewing the Aging Waiver LOCAs &/or CMI's. The Aging Waiver annual reassessment requires an RN signature for the LOCA's. How does that get paid, from the $226?	The assessment allocation for LOCA's and reassessments are set by the Department of Aging (PDA) for each AAA. This allocation is reconciled to actual costs but at a cap of $226 per assessment/ reassessment. The AAA's report all costs incurred to perform this function including the RN as required.

29	If we have an NHT contact due for a Waiver participant, can we count that also for one of the contact visits for Aging Waiver? Would it be billable under SC since we are already reimbursed under NHT.	Yes, you can count it as a contact visit. But, no, you cannot bill both NHT and SC.
30	Is it mandatory to have times listed in every single service note that is being entered as billable time?	Yes. SCs are required to list specific times.

October 16, 2012

	OLTL FAQs - 55 Pa. Code Chapter 52 - 10/16/12	
#	**Question**	**Answer**
	Enrollment - Provider and Consumer	
1	I understand that the regulation says services can't start unless there is an OLTL-approved service plan in place. Does this apply in cases where there is a delay in approval by OLTL because of IT problems or a backlog in the review process?	No. Section 52.14(g)(1) (relating to ongoing responsibilities of providers) of the HCBS regulation requires that a provider shall ensure that, prior to rendering services, the service plan is approved by the Office of Long-Term Living (OLTL). The intent of this provision is to stop the practice of some providers of initiating services before OLTL approves service plans. Even though there may be occasional technical difficulties or backlogs in review of service plans by OLTL, services to consumers must continue while these difficulties are resolved.
1A	I am still confused. What are providers supposed to do if there is no approved service plan in place because OLTL is behind in their reviews or there is no approved plan because of OLTL technical/IT problems?	If there is an enrolled participant and a service plan is in place and there is a delay in review and approval of annual plans, or there is a delay in review and approval of changes to that plan throughout the year due to the Commonwealth, the provider WILL be paid. However, payment will NOT be made for services rendered to someone who is not enrolled in a waiver or who does not have a service plan in place prior to enrollment and the approval of their service plan.
1B	We still need a little more clarification. What are providers supposed to do if there is no approved service plan in place because OLTL is behind in their reviews or there is no approved plan because of OLTL technical/IT problems?	(a) For a newly enrolled participant with a new service plan, providers should not be providing services until that plan is approved. (b) For existing participants with a change to their service plan, which may include Annual Reviews, the provider must continue to provide services at the prior approval level until changes are authorized.
2	What are the exact dates when the services and the supports coordination activities must be split apart?	Conflict Free Service Coordination goes into effect on July 1, 2012. By June 15, providers were to inform OLTL of which service they intend to offer - service coordination or direct services. OLTL will work with providers on developing a reasonable transition plan and provide assistance where appropriate. If you have not submitted the Conflict Free Choice Form, please submit it to: RA-HCBS-REG@pa.gov.
3	If an agency is doing service coordination and direct service, and if they are going to split into two “arms length” agencies, and if they need to make a request to the Department of Health (DOH) to move the Home Care license from one agency to another, will OLTL cite them if they have documentation in their file that they requested the moving of the license but haven’t yet had a response from DOH? OR, will OLTL not allow them to provide service until DOH either moves this license or issues a new one?	If an agency decides to split into Group A and Group B, both groups are required to comply with the appropriate licensing law as well as all regulations that govern each entity.
4	Is the Conflict Free Service Coordination Choice Form the only enrollment requirement that has to be completed by the AAAs? Are there any other enrollment requirements if the agency has only had the administrative care management program through a contract?	The Conflict Free Service Coordination Choice Form is for any agency, including Area Agencies on Aging (AAAs), who desire to become or are currently a Service Coordination Entity (SCE). Please contact the Bureau of Provider Support (BPS) for any additional paper requirements.
5	What process will be utilized by service coordination agencies to indicate what population should be served? Will there be requirements to serve waiver "populations"?	The intent of this question is unclear. Service Coordination agencies can serve participants in all waivers or opt to serve only participants in certain waivers.
6	If a county has only one home delivery meal provider serving Aging Waiver participants, and the provider is the parent agency, how can that provider comply with the regulation when there are no other providers in the county to serve those consumers?	As an Organized Health Care Delivery System (OHCDS) provider, the agency is able to maintain the home delivered meal service.

7	Is it correct that there is no conflict of interest for SCE and Financial Management Services (FMS) providers that may be chosen to provide FMS services? There is conflicting language. The SC Regulations state that this is not a conflict, but the Request for Application (RFA) states that it is a conflict. Although there is no conflict for those providers at this time, will there be a conflict on December 31st or when all consumers have been transferred to the new FMS provider?	Yes. FMS providers will only be permitted to continue to provide FMS services until the new vendor has transitioned participants.
8	Where can the rules and regulations be found for Procedural Code W1793, Personal Assistance Services (Aging Model) and the requirements that are required to hire employees, maintain cases, etc.?	Providers should refer to the applicable waiver for requirements for agency model of services. The waivers can be found at: http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733116&mode=2.
9	For AAAs who wish to enroll as service coordination entities, what process occurs to indicate the region they wish to serve?	AAAs should contact the Bureau of Provider Support (BPS) at 1-800-932-0939 for instructions on enrollment.
10	Timeframes are needed to accomplish waiver agreement modification and should be factored into the enrollment process. What steps have been taken to date?	AAAs received a letter on or before June 1, 2012, stating that "The Commonwealth is making this change pursuant to Paragraph 8 of the grant agreement which allows the Commonwealth to modify the required grant services by providing thirty (30) days written notice to the Grantee."
11	Is the two step tuberculosis (TB) immunization required upon hire and the one step TB immunization annually?	TB immunization requirements are in the PA Department of Health (DOH) Home Care regulations. Please refer to them or contact your County Health Department for additional information.
12	How will the data reporting changes be handled: HCSIS for AAAs and SAMS for the under 60 waiver providers?	Instructions will be provided to those agencies as they enroll to provide services to new specific populations.
13	In regard to the enrollment rate, reimbursement is for "successful" enrollments only. Did the rate methodology take into account staff time that it takes attempting to enroll a consumer who, subsequently, is determined to not be eligible for the Aging Waiver.	OLTL is in the process of further examining the enrollment rate to determine if future changes will be made.
14	How will we be able to enter a service delivery for enrollment if we are not the coordination agency entering it into the care plan?	You should enter your agency as a Provider in DETAILS. Reference: SAMS Consolidation Module, Pre-Consolidation Webinars and Monday Morning Post Consolidation Webinars.
15	**The AAAs understand that there is an analysis of enrollment cost by region being conducted to ascertain AAA costs associated with performing this service? Is this assumption correct?**	**OLTL has met with representatives from the AAAs and the Pennsylvania Association of Area Agencies on Aging and is discussing an analysis of enrollment costs.**

	Conflict Free Service Coordination	
1	In regards to conflict free service coordination, should agencies send a notification of eligibility to consumers for the services they decide not to provide?	Under 55 Pa. Code § 52.61. Provider cessation of services, the steps providers need to take if they decide to cease provision of services are outlined. Providers are required to send written notification to each participant, the Department of Public Welfare, Office of Long-Term Living, Bureau of Provider Support, 555 Walnut Street, Harrisburg, PA 17101), and other providers with whom the provider works stating that the provider is ceasing services at least 30 days prior to ceasing services. They must also notify their licensing or certifying entities as required. In addition, they must send to OLTL a copy of the notice they sent to participants and other providers. Furthermore, they must cooperate with OLTL, new providers and participants with transition planning to ensure continuity of care.
2	Can a provider split and start new corporations, one for service coordination and one for direct services?	Yes. Providers are required to follow 55 Pa. Code Chapter 52, including § 52.28 which addresses the requirements providers must meet to ensure that the agency is conflict free. In addition, § 52.61 addresses provider requirements for cessation of services, including transition planning to ensure the participant's continuity of care as well as provider sanctions. Also note that when participants leave one provider and transition to another, freedom of choice must be offered to each participant. Providers who are interested in forming new corporations should contact OLTL for information on timeframes.
3	What is the purpose of Conflict Free Service Coordination, if direct service providers are encouraged to open entities of service coordination, and FMS agencies can maintain Service Coordination? What outcomes does OLTL expect to accomplish differ from previous models?	FMS agencies are only permitted to maintain service coordination through December 2012. Providers must make their own business decisions and seek legal counsel to ensure that any new entities are conflict free. See §52.28(d) (relating to conflict free service coordination).
	Qualifications for Service Coordination	
1	If staff does not meet the service coordinator qualifications, should their employment be terminated?	Under 55 Pa. Code, the Home and Community-Based Services (HCBS) regulation does not provide for grandfathering of service coordinators. However, OLTL will review requests by agency directors on a case-by-case basis, and OLTL will work with them to bring their staff into compliance. Please send written requests to: RA-HCBSREG@pa.gov.
2	What are DPW's plans for training the new service coordination agencies, AAAs and others?	Ongoing service coordination training began in March 2012, and new provider training is scheduled quarterly on an ongoing basis. You can request the schedule of dates when new provider training will be held by contacting the Bureau of Provider Support.

3	Is it possible for a staff member who has been entering service orders for many years, who does not have the requisite college credits, to have an exemption from the qualifications? She is not doing anything other than entering them into the computer – it is purely data entry. I did see in Chapter 52 that it was possible to request exemptions on a prescribed form, but am not sure what that form is or where it can be located.	Only if the service coordinator enters data is it considered to be a component of service coordination. The time of data entry staff cannot be billed under service coordination.
	Service Coordination	
1	I have heard that RNs are "not required and have never been required."	All OLTL waivers provide that a registered nurse (RN) is either on staff with the Service Coordination agency or is available under contract as a nursing consultant to the Service Coordination agency. The RN is required to review and sign the standardized needs assessment for individuals who are ventilator dependent, technology dependent, require wound care, are non-compliant with medications, non-compliant with self-care, or if thewound care, are non compliant with medications, non compliant with self care, or if the participant requests to have an RN involved with the assessment of needs.
1A	In the most recent FAQs issued by OLTL on June 29, 2012, the question was asked again, "I have heard that RNs are not required and have never been required." OLTL's response did not address the real issue, which is does a homecare agency need to have a nurse to do the supervisory visit every 90 days.	The OLTL waivers do not stipulate that Personal Assistance Services agencies must have a nurse conduct a supervisory visit every 90 days. However, please check the Department of Health licensing requirements and Medicare requirements for your agency.
2	Can the service coordination entity (SCE) provide FMS for COMMCARE consumers under the new HCBS regulation? Does 55 Pa. Code Chapter 52 supersede the COMMCARE Waiver standards?	Yes. The SCE can provide FMS for COMMCARE consumers under 55 Pa. Code Chapter 52. However, DPW has issued a request for Application to select up to three vendors to provide FMS. Once the contract(s) is implemented, only the selected vendor(s) will provide FMS under all OLTL and Office of Developmental Programs (ODP) waivers and the Act 150 program. Yes. The new HCBS regulation supersedes the current COMMCARE Waiver standards.
3A	Under the process now, we have the RN visit the consumer twice a year. After reviewing the Service Coordination information, the RN home visit is not a component of service coordination? So does this mean that the RN does not have to visit the consumer during the year unless it is documented that a visit is required and justification is provided to implement it as a formal support?	Correct. An RN does not have to visit a consumer during the year unless it is documented that there is an assessed need for the visit.
3B	If it is documented that an RN must visit the consumer, how do we receive reimbursement for this?	Reimbursement occurs if it is a distinct service on the service plan and not part of service coordination.
4	Does the RN need to review and sign off on the LOCAs and CMIs once Service Coordination is implemented July 1st?	RNs must sign off on LOCAs. RNs must sign off on the CMI only when medically complex issues are involved or at the request of the participant (see Aging Waiver, Appendix D). http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733693&mode=2
5	Is the completion of the [LOCA] Annual recertification a function of service coordination or MA assessment?	Any changes to the service plan made as a result of the annual review are considered service coordination, which is to be billed through PROMISe.
6	Do we still enter a service delivery of Assessment, LOCA (Annual Recertification) since the time to do the LOCA will now be a billable service under Service Coordination? If we do not enter the Assessment does this affect reports being run for compliance purposes?	Conducting the LOCA is NOT a billable service under service coordination. It is a separate function paid for by Title XIX. There is no change in how LOCAs are documented in SAMS.
7	When we help the consumer complete their annual recertification's for DPW to determine their continued financial eligibility is that billable for service coordination?	Yes, refer to the Billing Bulletin at: http://www.portal.state.pa.us/portal/server.pt/community/bulletins/19451.

7A	**Why is conducting Medicaid financial eligibility determinations or redeterminations considered as non-billable; particularly the redeterminations? The initial SC Bulletin states that the SC cannot assist with financial redeterminations for PDA Waiver consumers. However, the 7-30 FAQ states under SC #7 "yes" to this question, thus, can a SC help with the annual recertification for DPW for financial eligibility?**	**It is considered non-billable because conducting financial eligibility is the job of the CAO. However, SCs assisting in collection of participant-required information is billable, including assisting the participant with the MA application, contact with the CAO, assisting with the appeals process if necessary, etc.**
8	Many AAAs have consumers who need help with personal care, but refuse it. They allow aides to do some home support. No one else is available to do home support. The home support code is now combined with the PAS agency code. (a) If consumers continue to refuse to have personal care (PC) tasks completed, do AAAs terminate them from the waiver? (b) If so, is termination appealable? (c) Do they need to give advance notice?	(a) Yes. The intent of PAS is to provide personal care needs, but it also depends on the circumstances. (b) Yes. (c) Yes.

9	Since the PAS agency definition in the Aging Waiver Application is the same as PAS Consumer Directed definition, can PAS Agency aides transport consumers to medical and non-medical visits without the same restrictions placed on transportation by personal care aides?	PAS has always been a service in the Aging Waiver and provided in the Aging Waiver as a PAS consumer-directed service. Personal Assistance Services (PAS) can be provided to participants through either the agency or self-directed models of service. When the service is provided through an agency, the agency makes the determination whether they will allow their employees to provide transportation to participants. When the participant is the employer of the PAS worker, the PAS worker can provide transportation for the participant. However, the PAS worker cannot be paid for both hours worked and mileage.
10	The level of care assessment (LOCA) and care management instrument (CMI) have sections in them to be completed by a nurse. How is that to be implemented?	There has been no change in policy on these matters. RNs are required to sign Level of Care Assessments. Only in limited cases where a participant has complex medical needs, or if they request it, must an RN sign the CMI. See OLTL waivers at: http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733116&mode=2.
11	Is it required that we have an RN do the supervisory visits every 90 days on PC cases through PDA?	The OLTL waivers do not stipulate that Personal Assistance Services agencies must have a nurse conduct a supervisory visit every 90 days. However, please check the Department of Health licensing requirements for your agency.
12A	What is the process for requesting approval of additional service coordination hours?	See page 4 of the Billing Instructions Bulletin, issued on June 5, 2012, which contains information on the process: Requests for additional units must be submitted through HCSIS and SAMS. Requests must include justification of why the initial amount was not enough and how the additional units will meet the needs of the participant. Specifically, this includes: • Identify the changes in the participant's condition, circumstances, informal supports, or any other changes that warrant the request; and • Provide justification related to the identified changes and how additional service coordination units will meet the identified needs. This information must be entered on the Service Notes screen (HCSIS) or in the Journal Notes (SAMS). The Service Coordinator must assess the need for service coordination and adjust the service plan as necessary throughout the year and annually. The Billing Instructions Bulletin may be found at the following link: http://www.portal.state.pa.us/portal/server.pt/community/bulletins/19451.
12B	As long as you stay under 144 units a year, can you exceed 12 units per month?	Yes. The 144 units is a yearly, flexible limitation. Service Coordinators may see increased and decreased service coordination needs from month to month depending on the needs of each participant.
12C	Are there recommendations on how to provide service coordination within the suggested cap?	Service coordination is provided based on the assessed needs of each individual waiver participant. The 144 unit cap is a soft cap. If a participant is unable to have their needs for service coordination met with 144 units per year, OLTL will consider requests for additional units. Requests for additional service coordination units cannot be submitted until 75% of the original authorized units have been used. The service coordinator should submit a request for additional units as described above.
12D	Will the cap be reviewed over time and changed if it is found that the hours exceed the recommended cap?	As a course of normal practice, OLTL monitors utilization of all services and looks for trends across agencies as well as across the overall program. Determination of where increases or decreases are made is dependent on analysis of utilization and budget considerations.
12E	**Since we have not known what to do, we have been submitting Service Plan Review Requests for additional Service Coordination to OLTL. This is not a situation where we have utilized 75% of our allocated units. These requests are due to prorating. Recently, all of our requests were approved for July in the mass approval. However, as there is not a mass approval every month, we will be in the same position next month without a solution.**	**As outlined in the OLTL Billing Instruction Bulletin, requests for additional service coordination units should not be submitted to OLTL until 75% of the original authorized units have been used. When developing initial Individual Service Plans for participants, Aging waiver Service Coordinators should not be prorating, as ISPs in SAMS are developed for a rolling 12-month period. For example, if a new participant is enrolled on April 1, that participant's ISP covers the period April 1 through March 31. However, Service Coordinators utilizing HCSIS should prorate Service Coordination units since ISPs in HCSIS are developed on a fiscal year. For example, if a new participant is enrolled on April 1, that participant's ISP covers the period April 1 through June 30, so Service Coordination units should be prorated based on an average of 12 units of service per month. In this example, the Service Coordination units would be 36. OLTL will be utilizing retrospective reviews to ensure that the service coordination units requested have appropriate justification.**
13	If a consumer reassessment is not due until September, do we carry out Care Management or do we start Service Coordination July 1st with this consumer?	Service Coordination became effective in the Aging Waiver upon approval of waiver amendments on July 1, 2012.
14	If we put the service coordinator as the subprovider, the only way to enter a service delivery is to enter that particular service coordinator. I don't think this issue has been adequately addressed. Also, if we enter daily service deliveries, will there be a report which we can run so that we are able to bill?	AAAs should enter Service Allocations and Service Orders in SAMS, not service deliveries. The Service Order will upload to HCSIS. The AAA will bill PROMISe for services rendered. PROMISe will interface with HCSIS to ensure that the number of units billed do not exceed the number of Units authorized in the Service Units. The Service Orders will always show the correct amount of units delivered. Reference: Service Coordination Module and Webinar.
15	If two SC visit a consumer at the same time due to safety concerns, can only one of the SC bill?	Yes, only one can bill for service coordination.

16	**Under most circumstances currently, 6 weeks or more may go by between the time when the agency receives the eligible PA162 and when the ISP is approved by OLTL. Since Service Coordination cannot be billed until OLTL approves the start of the ISP, this places the AAA at a great disadvantage for timely billing. What is being done to address this so that the AAAs can bill for Service Coordination in a timely manner?**	**Recently, the Department of Public Welfare reached settlement of the *Mosley vs. Alexander* litigation. The revised eligibility determination process requires activities to occur at scheduled intervals, regardless of whether a former step has been completed or not. The process culminates with the CAO issuing final eligibility determinations based on the results of the financial, clinical and programmatic determinations that occur as part of the process. This process can take no longer than 90 days in total to comply with federal statute. Beginning September 1, 2012, all applicants will receive eligibility determinations within 90 days of the date of their application.**
17	**Since eligibility for all waiver programs is determined by Nursing Facility Clinically Eligible status, how does OLTL/BIS determine medical needs? Is a request made to have a nurse assess the client to determine medical needs which require ongoing medical management?**	**The Level of Care Assessment (LOCA) that is performed by AAAs identifies whether or not an individual's health and/or condition make them clinically eligible for nursing facility level of care. RNs are required to sign off on all LOCAs. The Aging Waiver, as with all OLTL waivers, requires that a registered nurse is either on staff with the Service Coordination agency or is available under contract as a nursing consultant to the Service Coordination agency. The RN is required to review and sign the standardized needs assessment (CMI) for individuals who are ventilator dependent, technology dependent, require wound care, are non compliant with medications, ADL non-compliant (non-compliance with two or more ADL functions) or if the participant requests to have an RN involved with the assessment of needs. The Service Coordinator is responsible for notifying waiver participants that an RN is available should the participant wish to have a nurse included in the assessment process. This option is also incorporated into the standardized information packets that are distributed to all waiver participants. The requirement to either have an RN on staff or under contract is a component of the established Service Coordination rate. If nursing services are identified as a need through the standardized assessment process, this service should be included on the participant's service plan as a discrete service.**
18	**Whose responsibility is it to recruit providers for services? In one county a behavioral health provider has stopped doing business because the rates were insufficient to meet the costs of doing business. This service is not available to consumers.**	**Medicaid is a free-market system; providers decide to participate based upon the established rates and potential volume of business. However, when OLTL becomes aware that there is a provider access issue, OLTL is responsible for reviewing policies or making adjustments to policy which prevents providers from participating in the program. Service Coordinators should notify OLTL when a service is unavailable to participants due to no providers of service.**
19	**How are AAAs notified as to who provides Service Coordination in their planning service areas? How are AAAs notified when there are new Service Coordination agencies since offering a participant a choice of providers is part of the enrollment process?**	**The Bureau of Provider Supports will send a letter to a AAA when another service coordination agency has been enrolled to provide Aging Waiver service coordination in the same service area.**
20	**The Service Coordination training manual states that a AAA sends a written communication to consumers when OLTL approves a service. Is this the ISP or another form? Do we create our own form?**	**Every participant to be provided services must receive a copy of their approved service plan, as stated in the ISP Bulletin (issued October 20, 2010) at: http://www.portal.state.pa.us/portal/server.pt/community/bulletins/19451.**
21	**The AAAs have two separate forms that are sent relative to notification of adversep action and the right to appeal. Is there a standard form to use statewide?**	**As part of the work plan with CMS, OLTL is developing a standardized form andp p , p g process across all OLTL waivers for informing participants of adverse actions. The standardized form and training is forthcoming.**
22	**Some consumers have only home support. They refuse to have an aide help with personal care. PAS requires help with personal care. How do we handle these cases?**	**Waiver services cannot be provided if an individual refuses the minimum services that are requisite for enrollment in a waiver. In such a case, the service coordination entity may choose to pursue other funding mechanisms to support such an individual.**
	Rates	
1	What is the process to request a rate increase for the consumers who are part of the state program?	Rates are now standardized. There are no negotiated rates for waiver or Act 150 services.
2	Is there an update to the April 20, 2012 letter which included rate amendments that could be effective as soon as June 1?	Rates in the April 20, 2012 rate chart became effective June 1, 2012. On June 9, 2012, OLTL issued a bulletin that reviewed the rate-setting methodology, fee schedule rates, and vendor goods and services for the Medical Assistance Aging, Attendant Care, COMMCARE, Independence and OBRA Waivers as well as the Act 150 Program.
3	What are the exact rates? What is the exact date when they will take effect for each waiver.	All rates are effective on June 1, 2012, with two exceptions. Both Service Coordination and the Enrollment fee for the Aging Waiver take effect on July 1, 2012. See the following link for additional rate information: http://www.portal.state.pa.us/portal/server.pt/community/information_for_providers/19328.

4	Do the rates take into consideration overhead costs?	Overhead or indirect costs are included as a component of the OLTL HCBS market-based rates. Included in indirect costs are administrative expenses such as management, office supplies and equipment, recruitment, information technology, human resources, billing, finance, accounting, legal, and other indirect costs necessary for program operations.
5	The travel between consumers for one or two hour visits in counties with rural areas cannot be accomplished with the proposed rate. “We are required by Labor & Industry to pay travel time.”	OLTL's market-based rates factored in the cost of travel and non-productive time.
6	There appears to be regional disparities in the rates. Were the different needs of urban counties and those of rural counties considered in formulating the new rates?	In order to determine the regional groupings for OLTL HCBS rates, county specific wage information and population densities were obtained and utilized to evaluate the characteristic of each county looking for commonalities in geographic market cost variances.
7	Were increasing transportation issues and rising costs factored into the rates?	Both non-client time for travel and travel costs were utilized when setting the rates.

8	The new fee is lower than the service coordination currently reimbursed in PA's Mental Health (MH) system. What would indicate that the rates should be different?	The rates were developed based on a consistent definition for service coordination for all OLTL waivers, including the Aging Waiver. DPW's MH system has a number of targeted case management services, and each has a corresponding fee. OLTL has reviewed the MH definitions and none appear to be consistent with OLTL's service coordination definition.
9	Since rates are too low, we will have to begin to stop providing services on evenings, weekends and holidays. Are we allowed to do that?	No. As a provision of the provider agreement, OLTL waivers and the Home and Community-Based Services regulation, providers MUST provide services in the type, scope, amount, duration and frequency as indicated in the service plan and must assure for the health and safety of waiver participants. If a service plan indicates a need for services in the evening, weekend or holiday the provider MUST provide these services.
10	How was what is now considered to be non-billable time that is spent by care managers working with Aging Waiver consumers included in the rate methodology?	The market-based rate-setting methodology that was used to set the service coordination rate includes a non-client time component.
11	**Why is the Intellectual Disabilities (ID) system paid more for service coordination than we in the aging system are being paid?**	**The Supports Coordination service definition utilized by ODP is more expansive than OLTL’s Service Coordination service definition. One of the primary differences is that ODP requires Supports Coordinators to make three face-to-face monitoring visits every three calendar months; OLTL only requires face-to face visits twice a year and quarterly phone contacts. OLTL used a market-based methodology when developing rates for waiver services. However, OLTL has committed to review this rate and has established a workgroup with ten AAAs to evaluate the rate.**
	Billing	
1	Should providers begin billing using the new procedure codes and rates beginning June 1, 2012, or will these billings be rejected until all the information is in the Social Assistance Management System (SAMS) for all the counties?	The new rates were effective on June 1, 2012, but loaded into SAMS on June 4, 2012, except for enrollment for the Aging Waiver and service coordination services, which will go into effect on July 1, 2012.
2	Does nursing home transition fall into the definition of “community transition”? Is nursing home transition a “service” that AAAs would have to choose to eliminate in order to provide service coordination?	No. Nursing home transition is a different program than community transition services. Community Transition Services are one-time expenses for individuals that make the transition from an institution to their own home, apartment, or family/friend living arrangement.
3	The regulations state that if the participant is not available for service when a PCA shows up at the participant's home, no billing may occur. Is this considered a participant not being available for service? Or, does the regulation refer to when the agency is notified that the participant will not be home or is ill and cannot receive services. If so, what happens under the new regulations when a PCA shows up at the participant's home and the participant does not want services? Is this still billable since the PCA had to travel to the home?	If the service is not provided, a provider may not bill.
4	Is the intent to eliminate respite in the nursing home?	No. Nursing facility respite care is still allowed in the Aging Waiver. The nursing facility will bill PROMISe.
5	Will enrollment be a separate contract for the AAAs?	No. AAAs will bill PROMISe for successful enrollments.
6	Do Aging Waiver Providers need to supply gloves to their direct care workers when they provide consumers with personal assistance such as toileting? Can providers bill the state for the gloves?	Yes. Providers are required to supply gloves to direct care workers. *See,* Occupational Safety and Health Standards, 29 CFR § 1910.1030(d)(3). No. The cost is a component of the rate.
7	What services are billable and not billable?	Please refer to Billing Bulletin, Numbers 05-12-01, 51-12-01, 54-12-01, 55-12-01, and 5912-01 issued on June 5, 2012, specifically the procedure section.
8A	May smaller amounts of time for one consumer be accumulated to get one 15 minute billable unit? If so, what documentation is required?	Please refer to Billing Bulletin, Numbers 05-12-01, 51-12-01, 54-12-01, 55-12-01, and 5912-01 issued on June 5, 2012.

8B	A service coordinator often works in arranging services for a waiver participant by making numerous phone calls and conducting other activities such as initiating services, making adjustments to services or handling emergencies. Can all of this be considered billable time if done consecutively and is directly related to that one participant? For example, the service coordinator is setting up services for a new participant. The service coordinator calls several provider agencies to set up the services. This is all done in a consecutive time period. This takes 30 minutes total.	Yes. Since these were billable activities conducted in a consecutive time period, this can be billed as 2 billable 15-minute units of service coordination. The actual beginning and ending times for work activities related to a participant need to be documented. For example, *"10:03am-10:33am: Made calls on behalf of Mary to find a PAS provider for her. Those calls included agency A, B, and C."*
8C	Regarding the number of minutes being converted into billable units, why is 7.5-29.99 all considered 1 unit in your matrix?	When looking at a single billing activity, a unit is 15 minutes and 7.5 minutes rounded up equates to 15 minutes.
9	Where can we find information about the waivers, including service definitions and provider requirements?	Waiver information, including service definitions and provider requirements for all OLTL waivers can be found at: http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733116&mode=2.
10	When does a consumer's "participant" status begin, allowing billing for the participant as an Aging Waiver consumer?	A consumer's "participant" status begins upon receipt of the PA 162 by the AAA. Billing for services should not occur until after OLTL approves the service plan.
10A	We would like a clarification on question 10 under "Billing" of the 7-13-12 FAQ. The answer to the question states that even though a participant is considered to be enrolled in the Aging Waiver Program upon receipt of the PA162, no billing should occur prior to ISP approval. Does this just apply to direct services (such as PAS, PERS, etc.) or does it also apply to billing for service coordination and enrollment?	No billing is permitted to occur until there is an MA recipient number for an individual. It applies to service coordination and enrollment as well. The services must be on the plan and authorized in order to bill.
11	Can AAAs bill for assisting consumers in completing CAO financial renewal applications, which includes helping them complete the application, getting required verification, contacting CAO caseworkers on their behalf, etc.?	Please refer to Billing Bulletin, Numbers 05-12-01, 51-12-01, 54-12-01, 55-12-01, and 5912-01 issued on June 5, 2012. *(See Service Coordination #7A)*
12	Are the following services billable: Adult Day In Home Services, Ambulance Services, Medical Transportation, Music Therapy and Recreational Services?	These services are neither billable nor appealable.

12A	Music Therapists, who are currently a Provider Type 17, are not able to submit claims for June services successfully in PROMISe using Procedural Code H004. We are trying to determine if: (a) This is intentional and Music Therapists should change provider types, (b) This is unintentional and the two just need to be linked in the system, or (c) Music Therapists should be using a different code.	Music Therapy is neither billable nor appealable.
12B	We are no longer able to add S5185 (medication set-up by pharmacy) to our service plans. We have many consumers who use this service. It was not listed on the cross-walk as a discontinued service, and it was not listed as a service that was cross-walked to another code. The problem was it was not listed at all. What are we to do with our consumers who are currently using this service?	As of June 1, 2012, S5185 - Medication Set-up by Pharmacist is no longer a covered service in the waiver. Neither the waiver nor MA fee for service covers medication set up as a separate billable activity.
12C	Are interpreter Services billable?	No. Interpreter Services are not billable. Under Federal law, your Medicaid provider agreement and the waivers require providers to provide oral and written assistance to Limited English Proficient (LEP) persons to aid them to access and use services. Compliance with this provision is included as a component of the service rate.
13	Since our case aides and clerical staff perform some of the face-to-face visits, phone calls and SAMS functions, is case aide/clerical time billable?	No. Case aide/clerical time is not billable as service coordination. Clerical and administrative support is included as a component of the rate and is part of the rate.
14	Would an RN home visit be billed at a separate rate, such as a nursing visit? Would an RN paper review be billed at a separate rate which would reflect her/his advanced expertise?	RN review of a service plan is billed as part of service coordination.
15	If an RN home visit or review is necessary and to be included in the service coordination rate, is there an "enhanced" SC rate to allow for the additional cost?	Home visits are services that, if based on a documented assessed need, would be added to the service plan as a discrete service. There is no enhanced rate.
16	When an RN is required to sign off the CMI, how do we bill for that event? Is it allowed to be Service Coordination and can it be entered by the RN even though they do not meet the Service Coordinator requirement or can the Service Coordinator enter the review time for the RN?	RN sign off on the CMI is billable as a part of Service Coordination. A licensed RN is considered to met the qualifications as service coordinators.
17	There are times that consumers may be in the hospital and are considered suspended. We know service providers will not and should not be able to bill during this time. Service Coordinators could be assisting with the discharge planning etc. Is this billable time or will service coordination also be suspended and activities will not be billable during this time?	Service coordination will be suspended and activities will not be billable during that time. Any services provided on the date of discharge are billable as service coordination.
18	Our Meal cost has increased from FY 11-12 into FY 12-13. Can you tell me if this increase is ok or do we have to request a rate increase? Our HDM rate is comprised of the meal cost and the cost to prepare and transport.	Meal cost is not a published fee schedule rate. It is billed under Vendor Goods and Services; see http://www.pabulletin.com/secure/data/vol42/42-23/1058.html. Therefore, there is no need to request an increase.

19	If an Aging Waiver consumer passes away, is the time spent closing the case billable, ex. Contacting providers, fax termination orders, documentation, completing 1768 and sending to County Assistance Office?	Billing can occur after the date of death; the date of service cannot be after the date of death.
20	When we bill for service coordination, are we permitted to bill for supervision?	No. Supervisory activities are built into the rate.
21	Under the new Service Coordination regulations, how does the AAA bill for the successfulUnder the new Service Coordination regulations, how does the AAA bill for the successful enrollment once the PA 162 is received, but the consumer departs from the program (i.e. passes away, enters a Nursing Facility, voluntarily withdraws) prior to receiving OLTL approval for the care plan?	The enrollment service must be authorized before billing can occur. Once this occurs andThe enrollment service must be authorized before billing can occur. Once this occurs and the AAA has the 162, they can bill PROMISe. Date of service cannot occur after the date of death.
22	I am concerned that the delay in billing for service coordination and enrollment will jeopardize our ability to receive reimbursement for activities completed prior to ISP approval. For example, what if a consumer dies or is placed in a nursing facility before the ISP is approved?	Accelerated reviews for individuals in imminent risk of being placed in a nursing home are available by contacting OLTL at 717-787-8091.
23	In your example of a 30-minute home visit, is there some other place that topics discussed need to be recorded?	The only requirement is that billable and non-billable units are documented in Journal Entries.
24	What if a consumer switches counties - can the new agency bill for the W0009?	No. A new enrollment is not needed.
25	Can a supervisor bill for a billable activity when he/she is covering service coordination duties for a service coordinator?	If a service coordination supervisor is qualified as a service coordinator, they can perform service coordinator duties at the service coordination rate.
26	Are we required to enter a journal entry for every billable activity?	Yes. It is one of the basic principles of social work to enter case narrative for every action/activity done for or on behalf of consumers. Activities that are not documented and billed may be disallowed as the result of a monitoring/audit.
27	**From the initial call to the participant to schedule the appointment to submitting the ISP to OLTL for review takes 2-4 hours. When the ISP is approved by OLTL it takes the service coordinator an additional 1-2 hours to authorize services (contacting the provider, contacting the participant, updating the service plan, generating service orders, etc.). Because the participant is care managed by Options we are not able to bill for these activities. Is there a possibility we will be able to bill for the service coordination Aging Waiver provided?**	**This is not an allowable practice. If a person is receiving services through another funding source, waiver funds cannot be used retroactively.**
28	**How do we bill RN services under the new billing codes?**	**If a waiver participant requires nursing services, this service should be included on the participant's service plan. Home Health – Nursing is a discrete service that is available in many of OLTL's waivers. The provider type and provider qualifications for nursing providers can be found in the respective waivers; the appropriate procedure code can be found in the OLTL Billing Instructions Bulletin.**

June 25, 2012

	OLTL FAQs - 55 Pa. Code Chapter 52 - 6/25/12	
#	**Question**	**Answer**
	Enrollment - Provider/Consumer	

1	I understand that the regulation says services can't start unless there is an OLTL-approved service plan in place. Does this apply in cases where there is a delay in approval by OLTL because of IT problems or a backlog in the review process?	No. Section 52.14(g)(1) (relating to ongoing responsibilities of providers) requires that a provider shall ensure that, prior to rendering services, the service plan is approved by OLTL. The intent of this provision is to stop the practice of some providers of initiating services before OLTL approves service plans. Even though there may be occasional technical difficulties or backlogs in review of service plans by OLTL, services to consumers must continue while these difficulties are resolved.
2	What are the exact dates when the services and the supports coordination activities must be split apart?	Conflict Free Service Coordination goes into effect on July 1, 2012. By June 15, providers were to inform the Office of Long-Term Living (OLTL) of which service they intend to offer -service coordination or direct services. OLTL will work with providers on developing a reasonable transition plan and provide assistance where appropriate. If you have not submitted the Conflict Free Choice Form, submit it to: Department of Public Welfare, Office of Long-Term Living, Bureau of Provider Support, 555 Walnut Street, Harrisburg, PA 17101, ATTENTION: Rachel George.
3	If an agency is doing service coordination and direct service, and if they are going to split into two “arms length” agencies, and if they need to make a request to Department of Health (DOH) to move the Home Care license from one agency to another, will OLTL cite them if they have documentation in their file that they requested the moving of the license but haven’t yet h d f DOH? OR ill OLTL t ll th thad a response from DOH? OR, will OLTL not allow them to provide service until DOH either moves this license or issues a new one?	If an agency decides to split into Group A and Group B, both groups are required to comply with the appropriate licensing law as well as all regulations that govern each entity.
4	Is the Conflict Free Service Coordination Choice Form the only enrollment requirement that has to be completed by the AAAs? Are there any other enrollment requirements if the agency has only had the administrative care management program through a contract?	The Conflict Free Service Coordination Choice Form is for any agency, including Area Agencies on Aging (AAAs), who desire to become or are currently a Service Coordination Entity (SCE). Please contact the Bureau of Provider Support (BPS) for any additional paper requirements.
5	What process will be utilized by service coordination agencies to indicate what population should be served? Will there be requirements to serve waiver "populations"?	The intent of this question is unclear. Service Coordination agencies can serve participants in all waivers or opt to serve only participants in certain waivers.
6	If a county has only one home delivery meal provider serving Aging Waiver participants, and the provider is the parent agency, how can that provider comply with the regulation when there are no other providers in the county to serve those consumers?	As an Organized Health Care Delivery System (OHCDS) provider, the agency is able to maintain the home delivered meal service.

7	Is it correct that there is no conflict of interest for SCE and Financial Management Services (FMS) providers that may be chosen to provide FMS services? There is conflicting language. The SC Regulations state that this is not a conflict, but the Request for Application (RFA) states that it is a conflict. Although there is no conflict for those providers at this time, will there be a conflict on December 31st or when all consumers have been transferred to the new FMS provider?	Yes. FMS providers will only be permitted to continue to provide FMS services until the new vendor has transitioned participants.
8	Where can the rules and regulations be found for Procedural Code W1793, Personal Assistance Services (Aging Model) and the requirements that are required to hire employees, maintain cases, etc.?	Providers should refer to the applicable waiver for requirements for agency model of services. The waivers can be found at: http://www.portal.state.pa.us/portal/server.pt?open=514&objID =733116&mode=2
9	For AAAs who wish to enroll as service coordination entities, what process occurs to indicate the region they wish to serve?	AAAs should contact the Bureau of Provider Support (BPS) at 1-800-932-0939 for instructions on enrollment.
	Conflict Free Service Coordination	
1	In regards to conflict free service coordination, should agencies send a notification of eligibility to consumers for the services they decide not to provide?	Under 55 Pa. Code § 52.61. Provider cessation of services, the steps providers need to take if they decide to cease provision of services are outlined. Providers are required to send written notification to each participant, the Department (Department of Public Welfare, Office of Long-Term Living, Bureau of Provider Support, 555 Walnut Street, Harrisburg, PA 17101), and other providers with whom the provider works stating that the provider is ceasing services at least 30 days prior to ceasing services. They must also notify their licensing or certifying entities as required. In addition, they must send to OLTL a copy of the notice they sent to participants and other providers. Furthermore, they must cooperate with OLTL, new providers and participants with transition planning to ensure continuityy of care.
	Qualifications for Service Coordination	
1	If staff does not meet the service coordinator qualifications, should their employment be terminated?	Title 55 Pa. Code Chapter 52, the Home and Community-Based Services (HCBS) regulation, does not provide for the grandfathering of service coordinators. However, OLTL will review requests by agency directors on a case-by-case basis, and OLTL will work with them to bring their staff into compliance. Send written requests to: Nancy MacLeod in OLTL Project Management at c-nmacleod@pa.gov.
	Service Plan	

1	I have heard that RNS are "not required and have never been required."	All OLTL waivers provide that a registered nurse (RN) is either on staff with the Service Coordination agency or is available under contract as a nursing consultant to the Service Coordination agency. The RN is required to review and sign the standardized needs assessment for individuals who are ventilator dependent, technology dependent, require wound care, are non-compliant with medications, non-compliant with self-care or if the participant requests to have an RN involved with the assessment of needs.
	Rates	
1	What is the process to request a rate increase for the consumers who are part of the state program?	Rates are now standardized. There are no negotiated rates for waiver or Act 150 services.

2	Is there an update to the April 20, 2012 letter which included rate amendments that could be effective as soon as June 1?	Rates in the April 20, 2012 rate chart became effective June 1, 2012. On June 9, 2012, OLTL issued an online bulletin that reviewed the rate-setting methodology, fee schedule rates and vendor goods and services for the Medical Assistance Aging, Attendant Care, COMMCARE, Independence and OBRA Waivers as well as the Act 150 Program.
3	What are the exact rates? What is the exact date when they will take effect for each waiver.	All rates are effective on June 1, 2012, with two exceptions. Both Service Coordination and the Enrollment fee for the Aging Waiver take effect on July 1, 2012. See the following link for additional rate information: http://www.portal.state.pa.us/portal/server.pt/community/information_for_providers/19328
4	Do the rates take into consideration overhead costs?	Overhead or indirect costs are included as a component of the OLTL HCBS market based rates. Included in indirect costs are administrative expenses such as management, office supplies and equipment, recruitment, information technology, human resources, billing, finance, accounting, legal, and other indirect costs necessary for program operations.
5	The travel between consumers for one or two hour visits in counties with rural areas cannot be accomplished with the proposed rate. “We are required by Labor & Industry to pay travel time.”	OLTL's market-based rates factored in the cost of travel and non-productive time.
	Billing	
1	Should providers begin billing using the new procedure codes and rates beginning June 1, 2012, or will these billings be rejected until all the information is in the Social Assistance Management System (SAMS) for all the counties?	The new rates were effective on June 1, 2012, but loaded into SAMS on June 4, 2012, except for enrollment for the Aging Waiver and service coordination services, which will go into effect on July 1, 2012.
2	Does nursing home transition fall into the definition of “community transition” ? Is nursing home transition a “service”community transition ? Is nursing home transition a service that AAAs would have to choose to eliminate in order to provide service coordination?	No. Nursing home transition is a different program than community transition services. Community Transition community transition services. Community Transition Services are one-time expenses for individuals that make the transition from an institution to their own home, apartment, or family/friend living arrangement.

3	The regulations state that if the participant is not available for service when a PCA shows up at the participant's home, no billing may occur. Is this considered a participant not being available for service? Or, does the regulation refer to when the agency is notified that the participant will not be home or is ill and cannot receive services. If so, what happens under the new regulations when a PCA shows up at the participant's home and the participant does not want services? Is this still billable since the PCA had to travel to the home?	If the service is not provided, a provider may not bill.
4	Is the intent to eliminate respite in the nursing home?	No. Nursing facility respite care is still allowed in the Aging Waiver. The nursing facility will bill PROMISe.
5	Will enrollment be a separate contract for the AAAs?	No. AAAs will bill PROMISe for successful enrollments.
6	Do Aging Waiver Providers need to supply gloves to their direct care workers when their employed provide consumers with personal assistance such as toileting? Can providers bill the state for the gloves?	Yes. Providers are required to supply gloves to direct care workers. *See,* Occupational Safety and Health Standards, 29 CFR § 1910.1030(d)(3). No. The cost is a component of the rate.

CHAPTER 52. LONG-TERM LIVING HOME AND COMMUNITY-BASED SERVICES

52.1. Purpose.

This chapter specifies the provider qualifications and payment provisions for providers rendering services under the Aging, Attendant Care, COMMCARE, Independence and OBRA Home and Community-Based Service waivers and the Act 150 program.

§ 52.2. Scope.

This chapter sets forth the regulations which apply to providers applying to participate and render MA-funded waiver services under the Federally-approved Aging, Attendant Care, COMMCARE, Independence and OBRA Home and Community-Based Service waivers or the Act 150 program.

§ 52.3. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

ADL—Activities of daily living—The term includes eating, drinking, ambulating, transferring in and out of a bed or chair, toileting, bladder and bowel management, personal hygiene, self-

administering medication and proper turning and positioning in a bed or chair.

Act 150—A State-funded program under the Attendant Care Services Act (62 P. S. § § 3051—3058).

Aging waiver—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act (42 U.S.C.A § 1396n(c)) that authorizes services to participants 60 years of age or older.

Applicant—An individual or legal entity in the process of enrolling as a provider.

Attendant Care waiver—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act that authorizes services to participants 18 years of age or older but under 60 years of age with physical disabilities.

Attestation engagement—Financial services that result in the issuance of a report on a subject matter or an assertion about the subject matter that is the responsibility of another party. The term includes audits, examinations, reviews, compilations and agreed-upon procedures.

Back-up plan—A component of the service plan that is comprised of the individualized back-up plan and the emergency back-up plan.

CAP—Corrective action plan—A plan created by the provider or the Department to address provider noncompliance with this chapter.

CHAMPUS—Civilian Health and Medical Program of Uniformed Services.

COMMCARE—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act called the Community Care waiver that authorizes services to participants 21 years of age and older with traumatic brain injuries.

Community transition service—A one-time service which assists a participant to move from an institution to the participant's home, apartment or another noninstitu-tional living arrangement.

Community transition service provider—A provider who renders community transition services.

Complaint—Dissatisfaction with program operations, activities or services received, or not received, involving HCBS.

Critical incident—An occurrence of an event that jeopardizes the participant's health or welfare including:

(i) Death, serious injury or hospitalization of a participant. Pre-planned hospitalizations are not critical incidents.

(ii) Provider and staff member misconduct including deliberate, willful, unlawful or dishonest activities.

(iii) Abuse, including the infliction of injury, unreasonable confinement, intimidation, punishment or mental anguish, of the participant. Abuse includes the following:

(A) Physical abuse.

(B) Psychological abuse.

(C) Sexual abuse.

(D) Verbal abuse.

(iv) Neglect.

(v) Exploitation.

(vi) Service interruption, which is an event that results in the participant's inability to receive services and that places the participant's health or welfare at risk.

(vii) Medication errors that result in hospitalization, an emergency room visit or other medical intervention.

Department—The Department of Public Welfare of the Commonwealth.

Direct care worker—A person employed for compensation by a provider or participant who provides personal assistance services or respite services.

EPLS—Excluded Parties List System—A database maintained by the United States General Services Administration that provides information about parties that are excluded from receiving Federal contracts, certain subcontracts and certain Federal financial and nonfinancial assistance and benefits.

Emergency back-up plan—A plan which outlines the steps to be taken by the provider and the participant to ensure that the participant's needs are met in an emergency.

Fee schedule service—A service paid based on the MA Program fee schedule rates established by the Department.

Financial management services—A service which provides payroll, invoice processing and payment, fiscal reporting services, employer orientation, skills training and other fiscal-related services to participants choosing to exercise employer or participant-directed budget authority.

Financial review—A review of billing records against provider documentation to ensure services were provided in the type, scope, amount, duration and frequency as required by the participant's service plan and to ensure that a billing for a service rendered by a provider is accurate.

Finding—An identified violation of the following:

(i) This chapter.

(ii) The MA provider agreement, including the waiver addendum.

(iii) Chapter 1101 (relating to general provisions).

(iv) The approved applicable waiver, including approved waiver amendments.

(v) A State or Federal requirement.

HCBS—Home and community-based services—Services offered as part of a Federally-approved MA waiver or Act 150 program.

IADL—Instrumental activities of daily living—The term includes the following activities when done on behalf of a participant:

(i) Laundry.

(ii) Shopping.

(iii) Securing and using transportation.

(iv) Using a telephone.

(v) Making and keeping appointments.

(vi) Caring for personal possessions.

(vii) Writing correspondence.

(viii) Using a prosthetic device.

(ix) Housekeeping.

ICF/ORC—Intermediate care facility/other related conditions.

Independence waiver—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act that authorizes services to participants 18 years of age and older but under 60 years of age with physical disabilities.

Individualized back-up plan—A plan which outlines the steps to be taken by the provider and participant to ensure that services are delivered to the participant in a situation where routine service delivery is interrupted.

Informal community supports—Services provided by a family member, friend, community organization or other entity for which funding is not provided by the Department.

LEIE—List of Excluded Individuals and Entities—A database maintained by the United States Department of Health and Human Services, Office of the Inspector General, that identifies individuals or entities that have been excluded Nationwide from participation in a Federal health care program.

Level of care re-evaluation—A redetermination of a participant's clinical eligibility under a waiver or the Act 150 program.

MA—Medical Assistance.

MA provider agreement—An enrollment agreement signed by the provider which establishes requirements relating to the provision of services.

Medicaid—MA provided under a State Plan approved by the United States Department of Health and Human Services under Title XIX of the Social Security Act (42 U.S.C.A. § 1396a).

Medicaid State Plan—A plan to provide MA developed by the Department and approved by the United States Department of Health and Human Services under Title XIX of the Social Security Act which serves as the basis for Federal financial participation in the program.

Medicheck—A Departmental list identifying providers, individuals and other entities precluded from participation in the Commonwealth's MA Program.

Monitoring—A review of a provider's compliance.

Nursing facility—

(i) A long-term care facility that is:

(A) Licensed by the Department of Health.

(B) Enrolled in the MA Program as a provider of nursing facility services.

(C) Owned by a person, partnership, association or corporation and operated on a profit or nonprofit basis.

(ii) The term does not include the following:

(A) Intermediate care facilities for individuals with developmental or intellectual disabilities or other related conditions

(B) Federal or State-owned long-term care nursing facilities.

OBRA waiver—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act named for the Omnibus Budget and Reconciliation Act of 1981 (Pub. L. No. 97-35) that authorizes services to participants 18 years of age or older but under 60 years of age with developmental disabilities.

OHCDS—Organized Health Care Delivery System provider—A provider who is authorized by the Department to contract with an entity to provide a vendor good or service.

Participant—A person receiving services through a waiver or the Act 150 program.

Participant-directed budget authority—The spending authority granted to the participant through a waiver whereby the participant is authorized to spend the amount of money allocated in the participant's service plan on goods and services.

Participant goal—A service plan requirement that states a participant's objective towards obtaining or maintaining independence in the community.

Participant need—A service plan requirement based on a person-centered assessment.

Participant outcome—A service plan requirement that measures whether a service, TPR or informal community support is achieving a participant goal.

Person-centered approach—A holistic approach to serving participants which focuses on a participant's individual and specific strengths, interests and needs.

Person-centered assessment—A Department-approved questionnaire used to determine the specific needs of a participant by utilizing a person-centered approach.

Personal assistance services—Services aimed at assisting the participant to complete ADLs

and IADLs that would be performed independently if the participant did not have a disability.

Preventable incident—A critical incident that could be avoided through appropriate training of a staff member or participant following established policies and procedures or implementation of other reasonable precautionary measures.

Provider—A Department-enrolled entity which provides a service.

QMP—Quality Management Plan—A provider-created plan to address areas of quality improvement identified by the provider or the Department.

Respite services—Personal assistance services which are provided on a temporary, short-term basis when a noncompensated caregiver is unavailable to provide personal assistance services.

Risk mitigation strategies—Methods to reduce risks to a participant's health and safety.

SCE—Service coordination entity—A provider authorized to render service coordination services in a waiver or Act 150 program.

Service—A benefit which a participant receives under an approved MA waiver or the Act 150 program.

Service coordination—Service that assists a participant in gaining access to needed waiver services, MA State Plan services and other medical, social and educational services regardless of funding source.

Service coordinator—A staff member who provides service coordination services at an SCE.

Service plan—The Department-approved comprehensive written summary of a participant's services, TPR and informal community supports.

TPR—Third party medical resource—Medical resources used to pay for participant services, including Medicare, CHAMPUS, workers' compensation, for profit and nonprofit health care coverage and insurance policies, and other forms of insurances.

Vendor good or service—A rendered item or service that is not on the MA fee schedule for which the Department reimburses an OHCDS or provider.

Waiver—The Aging, Attendant Care, COMMCARE, Independence, and OBRA Home and Community-Based Service waivers approved by the Federal Centers for Medicare and Medicaid Services.

§ 52.4. Incorporation by reference.

The approved applicable Federal waivers, including approved waiver amendments, are incorporated by reference and can be found on the Department's web site at http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733116&mode=2.

Subchapter B. PROVIDER QUALIFICATIONS AND PARTICIPATION

Sec.

§ 52.11. Prerequisites for participation.

(a) As a condition of participation in a waiver or Act 150 program, an applicant shall meet the following qualifications:

(1) Complete and submit an MA application including a waiver addendum to that application.

(2) Complete and submit a signed MA provider agreement including the waiver addendum to that agreement.

(3) Verify fiscal solvency by submitting a copy of the following:

(i) Applicant's most recent corporate or nonprofit tax return. If an applicant does not have a corporate or nonprofit tax return, then the applicant shall submit the most recent individual tax return for the owner of the entity which is applying for enrollment.

(ii) Applicant's most recent monthly balance sheet. If an applicant does not have a balance sheet, then an applicant shall submit a copy of the business plan indicating assets, liabilities, and anticipated costs and revenues for the next fiscal year.

(iii) Articles of incorporation, if the applicant is incorporated.

(iv) Partnership agreement, if the applicant is a partnership.

(v) Most recent audit or financial review if the applicant has completed an audit or financial review within the previous 5 years.

(4) Area Agencies on Aging that are units of county government are not required to submit documentation under paragraph (3).

(5) Create and follow policies and procedures relating to the following:

(i) Compliance with this chapter.

(ii) Provision of services in a nondiscriminatory manner.

(iii) Compliance with the Americans with Disabilities Act of 1990 (42 U.S.C.A. § § 12101—12213).

(iv) Compliance with the Healthcare Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191).

(v) Staff member training. The policy must be in accordance with this chapter and licensing requirements that the applicant is required to meet.

(vi) Participant complaint management process.

(vii) Critical incident management. The policy must be in accordance with this chapter and licensing requirements that the applicant is required to meet.

(viii) Quality management. The policy must be in accordance with this chapter and licensing requirements that the applicant is required to meet.

(ix) Staff member screening for criminal history.

(x) Employee Social Security Number verification.

(xi) Initial and continued screening for staff members and contractors to determine if they have been excluded from participation in Federal health care programs by reviewing the LEIE, EPLS and Medicheck.

(xii) Process for participants with limited English proficiency to access language services.

(6) Obtain and maintain appropriate licenses and certifications from other State or Federal agencies as required.

(7) Obtain the following insurances:

(i) Commercial general liability insurance.

(ii) Worker's compensation insurance.

(iii) Professional liability insurance if required by a profession.

(8) Comply with the applicable approved waiver, including approved waiver amendments as posted on the Department's publicly accessible web site.

(b) An applicant shall submit verification of compliance with subsection (a) to the Department.

(c) Application materials shall be submitted to the Department in a form and manner as prescribed by the Department.

(d) An applicant may apply to become a provider of more than one service as long as the provision of multiple services is not prohibited by this chapter or Federal or State requirement.

Cross References

This section cited in 55 Pa. Code § 52.13 (relating to review of application); and 55 Pa. Code § 52.14 (relating to ongoing responsibilities of providers).

§ 52.12. Prerequisites for existing provider enrolling in a new service.

(a) If an existing provider enrolled in a waiver program wants to enroll to provide an additional waiver service, the provider shall submit the following to the Department:

(1) A written request to enroll as a provider of the additional service.

(2) A copy of the license required to provide the service if the service requires licensure.

(3) A completed and signed waiver addendum to the MA provider agreement for the new service.

(b) The provider shall submit the written request to enroll in an additional service to the Department in a form and manner prescribed by the Department.

§ 52.13. Review of application.

(a) The Department will only review complete application materials.

(b) The Department will review the application materials submitted under § 52.11 (relating to prerequisites for participation).

(c) The Department may request additional information from an applicant to verify the applicant is qualified to provide services in accordance with this chapter or other Federal or State requirements.

(d) Incomplete application materials are void after 30 days of receipt.

(e) The Department will notify the applicant if the applicant's application is incomplete.

(f) The Department is not required to return application materials to an applicant.

§ 52.14. Ongoing responsibilities of providers.

(a) An applicant is not a provider until the following are met:

(1) The Department approves the applicant's MA application.

(2) An MA provider agreement including a waiver addendum is signed.

(b) Within 180 days from the date of enrollment, a provider shall attend new provider training provided by the Department.

(c) A provider shall implement the policies under § 52.11(a)(5) (relating to prerequisites for participation).

(d) In addition to meeting the participation requirements under Chapter 1101 (relating to general provisions), a provider shall update and submit to the Department the provider qualifications under § 52.11(a)(3)—(7) at least every 2 years.

(e) In addition to meeting the requirements in § 1101.68 (relating to invoicing for services), the provider shall meet the requirements in the MA HCBS Provider Handbook, available on the Department's web site.

(f) A provider shall maintain appropriate licenses and certifications as required by State and Federal requirements. The provider shall submit a copy of a valid license or certification, or both, to the Department at the beginning of each applicable licensure period.

(g) The provider shall ensure the following prior to rendering services to a participant:

(1) The service plan is approved by the Department.

(2) The type, scope, amount, duration and frequency of the service to be rendered are listed in the service plan that the provider is assigned to implement.

(h) A provider shall ensure a participant is eligible to receive a service prior to rendering the service to the participant.

(i) A provider shall comply with the applicable approved waiver, including approved waiver amendments.

(j) The provider shall notify the Department at least 30 business days prior to any of the following occurrences:

(1) Changes in the provider's address, telephone number, fax number, e-mail address, provider name change or provider's designated contact person.

(2) Creation, changes or revocation of the provider's articles of incorporation or partnership agreements.

(3) Revisions to an audit previously submitted to the Department under § 52.11(a).

(4) Revocation or provisional status of a license or certification.

(5) Cancellation of the following insurances:

(i) Commercial general liability insurance.

(ii) Workers' compensation insurance.

(iii) Professional liability insurance if the profession authorized to provide a service requires professional liability insurance.

(k) If the provider is unable to notify the Department due to an emergency prior to a change occurring as stated under subsection (j), the provider shall notify the Department within 2 business days of the change.

(l) A provider shall ensure that each employee possesses a valid Social Security Number.

(m) A provider may not render a service when the participant is unavailable to receive the service.

(n) A provider may not bill for a service when the participant is unavailable to receive the service.

(o) A provider which is not an SCE shall cooperate with the participant, the SCE and the Department to resolve delays in service provision.

(p) A provider shall complete and comply with a CAP as required by the Department or other Federal or State agency.

(q) A provider shall implement and provide services to the participant in the type, scope, amount, duration and frequency as specified in the service plan.

(r) A provider shall document the participant's progress towards outcomes and goals in the Department's designated information system.

(s) The provider shall comply with the terms of the MA provider agreement, including waiver addendum.

(t) A provider shall participate in Department-mandated trainings.

§ 52.15. Provider records.

(a) The following requirements are in addition to the recordkeeping provisions under § 1101.51(d) and (e) (relating to ongoing responsibilities of providers):

(1) A provider shall use the Department's designated information system to record service plan information regarding the participant as required under § 52.25 (relating to service plan).

(2) A provider shall complete and maintain documentation on service delivery.

(b) Electronic records are acceptable documentation when the provider meets the following:

(1) The electronic format conforms to Federal and State requirements.

(2) The electronic record is the original record and has not been altered or if altered shows the original and altered versions, dates of creation and the creator.

(3) The electronic record is readily accessible to the Department, the Department's designee and State and Federal agencies.

(4) The provider creates and implements an electronic record retention policy.

(5) Electronic imaging of paper documentation must result in an exact reproduction of the original record and conform to the provider's electronic record retention policy.

(c) The provider shall ensure records are compliant with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191).

(d) The requirements of this section are in addition to the recordkeeping provisions in Chapters 2380 and 2390 (relating to adult training facilities; and vocational facilities), 6 Pa. Code Chapter 11 (relating to older adult daily living centers) and 28 Pa. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries).

Cross References

This section cited in 55 Pa. Code § 52.19 (relating to criminal history checks); and 55 Pa. Code § 52.43 (relating to audit requirements).

§ 52.16. Abuse.

(a) Abuse is an act or omission that willfully deprives a participant of rights or human dignity, or which may cause or causes actual physical injury or emotional harm to a participant including a critical incident and one or more of the following:

(1) Sexual harassment of a participant.

(2) Sexual contact between a staff member and a participant.

(3) Restraining a participant.

(4) Financial exploitation of a participant.

(5) Humiliating a participant.

(6) Withholding regularly scheduled meals from a participant.

(b) Abuse of a participant is prohibited.

§ 52.17. Critical incident and risk management.

(a) The requirements in this chapter are in addition to the reporting requirements under Chapter 2380 or 2390 (relating to adult training facilities; and vocational facilities), 6 Pa. Code Chapter 11 (relating to older adult daily living centers) and 28 Pa. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries).

(b) A provider shall report a critical incident involving a participant to the Department or the SCE, or both, on a form prescribed by the Department.

(c) A provider shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of critical incidents.

(d) A provider shall meet the risk management requirements as specified in the approved applicable waivers, including approved waiver amendments.

(e) If the Department requires additional follow-up information to a critical incident, then the provider shall submit additional information as requested to the Department.

(f) A provider shall reduce the number of preventable incidents. The methods used by the provider to reduce the number of preventable incidents shall be documented on the provider's QMP.

§ 52.18. Complaint management.

(a) The provider shall implement a system to record, respond and resolve a participant's complaint.

(b) The provider complaint system must contain the following:

(1) The name of the participant.

(2) The nature of the complaint.

(3) The date of the complaint.

(4) The provider's actions to resolve the complaint.

(5) The participant's satisfaction to the resolution of the complaint.

(c) The provider shall review the complaint system at least quarterly to:

(1) Analyze the number of complaints resolved to the participant's satisfaction.

(2) Analyze the number of complaints not resolved to the participant's satisfaction.

(3) Measure the number of complaints referred to the Department for resolution.

(d) The provider shall develop a QMP when the numbers of complaints resolved to a participant's satisfaction are less than the number of complaints not resolved to a participant's satisfaction.

(e) The provider shall submit a copy of the provider's complaint system procedures to the Department upon request.

(f) The provider shall submit the information under subsection (c) to the Department upon request.

§ 52.19. Criminal history checks.

(a) The criminal history requirements in this section are in addition to the requirements in Chapter 2380 or 2390 (relating to adult training facilities; and vocational facilities), 6 Pa. Code Chapter 11 (relating to older adult daily living centers) and 28 Pa. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries) for providers licensed under these chapters.

(b) Prior to hiring an employee, a provider shall obtain a criminal history check which is in compliance with the following for each employee who may have contact with a participant:

(1) A report of criminal history record information from the Pennsylvania State Police or a statement from the Pennsylvania State Police that the Pennsylvania State Police Central Repository does not contain information relating to that person, under 18 Pa.C.S. Chapter 91 (relating to Criminal History Record Information Act), if the employee has been a resident of this Commonwealth for the 2 years immediately preceding the date of application.

(2) A report of Federal criminal history record information under the Federal Bureau of Investigation appropriation of Title II of the act of October 25, 1972 (Pub. L. No. 92-544, 86 Stat. 1109) if the employee has not been a resident of this Commonwealth for the 2 years immediately preceding the date of application.

(c) Criminal history checks shall be in accordance with the Older Adults Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

(d) The hiring policies shall be in accordance with the Department of Aging's Older Adults Protective Services Act policy as posted on the Department of Aging's web site at http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616725&mode=2.

(e) A copy of the final report received from the Pennsylvania State Police or the Federal Bureau of Investigation, as applicable, shall be kept in accordance with § 52.15 (relating to provider records).

Cross References

This section cited in 55 Pa. Code § 52.20 (relating to provisional hiring).

§ 52.20. Provisional hiring.

(a) A provider may hire a person for employment on a provisional basis, pending receipt of a criminal history check, provided that the following are met:

(1) The provider is in the process of obtaining a criminal history check as required under § 52.19 (relating to criminal history checks).

(2) A provider may not hire a person provisionally if the provider has knowledge that the person would be disqualified for employment under 18 Pa.C.S. § 4911 (relating to tampering with public records or information).

(3) A provisionally-hired employee shall swear or affirm in writing that he is not disqualified from employment under this chapter.

(4) A provider shall monitor the provisionally-hired person awaiting a criminal history check through random, direct observation and participant feedback. The results of monitoring must be documented in the person's employment file.

(5) The period of provisional hire may not exceed 30 days for a person who has been a resident of this Commonwealth for at least 2 years.

(6) The period of provisional hire may not exceed 90 days for a person who has been a resident of this Commonwealth for less than 2 years.

(b) If the information obtained from the criminal history check reveals that the person is disqualified from employment under § 52.19, the provider shall terminate the provisionally-hired person immediately.

(c) When subsection (a) conflicts with Chapters 2380 and 2390 (relating to adult training facilities; and vocational facilities), 6 Pa. Code Chapter 11 (relating to older adult daily living

centers) or 28 Pa. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries), subsection (a) is not applicable.

Source

The provisions of this § 52.20 corrected February 8, 2013, effective May 19, 2012, 43 Pa.B. 833. Immediately preceding text appears at serial pages (361347) to (361348).

§ 52.21. Staff training.

(a) A provider shall meet the training requirements necessary to maintain appropriate licensure or certification, or both, in addition to meeting the training requirements of this chapter.

(b) Prior to providing a service to a participant, a staff member shall be trained on how to provide the service in accordance with the participant's service plan.

(c) A provider shall maintain documentation for the following:

(1) Staff member attendance at trainings.

(2) Content of trainings.

(d) A provider shall implement standard annual training for staff members providing services which contains at least the following:

(1) Prevention of abuse and exploitation of participants.

(2) Reporting critical incidents.

(3) Participant complaint resolution.

(4) Department-issued policies and procedures.

(5) Provider's quality management plan.

(6) Fraud and financial abuse prevention.

§ 52.22. Provider monitoring.

(a) The Department will monitor a provider at least once every 2 years.

(b) Monitoring may be announced or unannounced.

(c) A provider shall submit documentation as requested by the Department that the provider is in compliance with the following:

(1) This chapter.

(2) The MA provider agreement, including the waiver addendum.

(3) Chapter 1101 (relating to general provisions).

(4) The approved applicable waiver, including approved waiver amendments.

(5) A State or Federal requirement.

(d) The Department will issue a written statement of findings if the provider has not complied with subsection (c).

Cross References

This section cited in 55 Pa. Code § 52.23 (relating to corrective action plan).

§ 52.23. Corrective action plan.

(a) The provider shall respond to the written statement of findings under § 52.22 (relating to provider monitoring) with a CAP when requested by the Department.

(b) The provider shall submit a CAP to the Department on a form prescribed by the Department.

(c) The CAP must contain at least the following:

(1) The provider's name.

(2) The provider's address.

(3) The provider's MA identification number.

(4) The action steps to address a specific finding.

(5) The dates action steps will be completed.

(6) An explanation on how the action steps will remediate the finding.

(7) The date when a finding will be remediated.

(8) The provider's signature indicating the provider will implement the CAP.

(d) The Department will review and monitor a provider-drafted CAP to ensure each finding is corrected.

(e) The Department may reject a provider-drafted CAP and request the provider to revise the CAP so the CAP is in compliance with this section.

(f) The Department may develop a CAP for a provider to implement in response to the statement of findings.

(g) The provider shall implement a Department-approved CAP.

(h) The Department may conduct a follow-up monitoring to ensure the provider is implementing the CAP.

§ 52.24. Quality management.

(a) The provider shall create and implement a QMP to ensure the provider meets the requirements of this chapter and Chapter 1101 (relating to general provisions).

(b) The QMP must contain at least the following:

(1) Measureable goals to ensure compliance with this chapter, Chapter 1101 and other chapters in this title under which the provider is licensed.

(2) Data-driven outcomes to achieve compliance with this chapter, Chapter 1101 and other chapters in this title which the provider is licensed.

(3) The current Department-approved CAP, if the provider has a CAP.

(c) The provider may add additional items to the QMP to address self-identified areas of quality improvement.

(d) The QMP must be updated at least annually by the provider.

(e) The Department may request a provider to update the provider's QMP if the provider receives a CAP.

(f) The provider shall submit a copy of the QMP to the Department upon request.

§ 52.25. Service plan. Service Coordination Entity

(a) A service plan must be developed for each participant that contains the following:

(1) The participant need as identified on a standardized needs assessment provided by the Department.

(2) The participant goal.

(3) The participant outcome.

(4) Service, TPR or informal community support that meets the participant need, participant goal or participant outcome.

(5) The type, scope, amount, duration and frequency of services needed by the participant.

(6) The provider of each service.

(7) The participant's signature.

(8) Risk mitigation strategies.

(9) The participant's back-up plan.

(b) The participant's back-up plan must contain an individualized back-up plan and an emergency back-up plan.

(c) Each participant need must be addressed by an informal community support, TPR or service unless the participant chooses for a need to not be addressed.

(d) If a participant refuses to have a need addressed, then the SCE shall document when the participant refused to have the need addressed and why the participant chose for the need to remain unaddressed.

(e) The following services require a physician's prescription prior to being added to a participant's service plan:

(1) Physical therapy.

(2) Occupational therapy.

(3) Speech and language therapy.

(4) Nursing services.

(5) Telecare health status and monitoring services.

(6) Durable medical equipment.

(f) An SCE or the Department's designee shall use a person-centered approach to develop the participant's service plan.

(g) An SCE or the Department's designee shall use the Department's person-centered assessment and risk assessment to develop the participant's service plan.

(h) An SCE or the Department's designee shall complete the participant's service plan on a format prescribed by the Department and enter the service plan into the Department's designated information system.

(i) The Department will approve the participant's service plan prior to service provision.

(j) An SCE or the Department's designee shall review the participant need, participant goal and participant outcome documented on the service plan at least annually with the participant.

(k) An SCE or the Department's designee shall review and modify, if necessary, the participant need, participant goal and participant outcome each time a participant has a significant change in medical or social condition.

(l) If there has been a significant change in the medical or social condition of a participant, an SCE or the Department's designee shall use the Department's person-centered assessment and risk assessment to determine if changes are needed in the participant's service plan.

Cross References

This section cited in 55 Pa. Code § 52.15 (relating to provider records).

§ 52.26. Service coordination services.

(a) To be paid for rendering service coordination services, an SCE shall:

(1) Complete a person-centered assessment.

(2) Complete a level of care re-evaluation at least annually.

(3) Develop a service plan for each participant for whom the SCE renders service coordination services. The provider shall complete the following:

(i) Develop and modify the participant's service plan at least annually.

(ii) Modify the participant's service plan, if necessary, when the participant has a significant medical or social change.

(4) Review the participant need, the participant goal and participant outcome with the participant and other persons that the participant requests to be part of the review as required by conducting the following:

(i) At least one telephone call or face-to-face visit per calendar quarter. At least two face-to-face visits are required per calendar year.

(ii) More frequent calls or visits if the service coordinator or the Department determines more frequent calls or visits are necessary to ensure the participant's health and safety.

(5) Coordinate a service, TPR and informal community supports with the participant to ensure the participant need, the participant goal and the participant outcome are met.

(6) Provide the participant with a list of providers in the participant's service location area that are enrolled to render the service that meet the participant needs.

(7) Inform the participant of the participant's right to choose any willing and qualified provider to provide a service on the participant's service plan.

(8) Confirm with the participant's selected provider that the provider is able to provide the service in the type, scope, amount, duration and frequency as listed on the participant's service plan.

(9) Provide information regarding the authorized type, scope, amount, duration and frequency of services as listed in the participant's service plan to the provider rendering the service.

(10) Ensure and document at least on a quarterly basis that the participant's services are being delivered in the type, scope, amount, duration and frequency as required by the participant's service plan.

(11) Evaluate if the participant need, participant goal and participant outcome are being met by the service.

(12) Ensure a participant exercising participant-directed budget authority does not exceed the number of service hours approved in the participant's service plan.

(b) If additional information is necessary to ensure that services are provided to a participant in the type, scope, amount, duration or frequency as required by the participant's service plan, the SCE shall convey the additional information to a provider.

(c) The SCE shall ensure a waiver or Act 150 service assigned to a participant is a service offered under the waiver or Act 150 service in which the participant is enrolled.

(d) If a participant is available to receive only a portion of the service coordination services in subsection (a), the Department will pay for those portions of the services rendered to the participant.

(e) If the SCE is an OHCDS, then the SCE shall be a direct service provider of at least one vendor good or service.

(f) If services are not being delivered by a provider to a participant in the type, scope, amount, duration or frequency as required by the participant's service plan, then the SCE shall work with the provider to do either of the following:

(1) Ensure that services are being delivered to the participant in the type, scope, amount, duration and frequency required by the participant's service plan.

(2) Transition the participant to a provider who is willing and qualified to provide services to the participant in accordance with the participant's service plan.

(g) The Department may limit the number of service coordination units available to participants as provided in the approved applicable waiver, including approved waiver amendments.

(h) A provider may not bill for more units of service coordination services for a participant than provided for in the participant's service plan.

(i) If a participant requires more units of service coordination services than provided for in the participant's service plan, then the SCE shall submit:

(1) A request to increase the number of service coordination units for the participant to the Department.

(2) Justification for why the participant requires more units of service.

(3) The number of service coordination units the participant is assessed to need.

(j) If the service is also offered as a Medicaid State Plan service, then the Medicaid State Plan service shall be accessed prior to another Departmental program to provide the service.

(k) The SCE or the Department's designee shall assist a participant to collect and send information to the Department to determine the participant's continued eligibility for the waiver or Act 150 program, including financial eligibility.

Source

The provisions of this § 52.26(g) and (i) effective June 27, 2012, 42 Pa.B. 4545. Immediately preceding text appears at serial pages (361351) to (361353).

§ 52.28. Conflict free service coordination.

(a) An SCE may not provide other waiver or Act 150 services if the SCE provides service coordination services unless one of the following is applicable:

(1) The SCE is providing the service as an OHCDS under § 52.53 (relating to organized health care delivery system).

(2) The SCE is providing community transition services to a participant transitioning from a nursing facility or an ICF/ORC.

(3) The SCE is providing financial management services to a participant.

(b) If an SCE operates as an OHCDS, then the SCE may not require a participant to use that OHCDS as a condition to receive the service coordination services of the SCE.

(c) An SCE may not require a participant to choose the SCE as the participant's community transition service provider as a condition to receive service coordination services.

(d) An SCE and a provider of a service other than service coordination may not share any of the following:

(1) Chief executive officer or equivalent.

(2) Executive board.

(3) Bank account.

(4) Supervisory staff.

(5) Tax identification number.

(6) MA provider agreement.

(7) Master provider index number.

Source

The provisions of this § 52.28 effective June 27, 2012, 42 Pa.B. 4545. Immediately preceding text appears at serial pages (361354) to (361355).

§ 52.29. Confidentiality of records.

Participant records must be kept confidential and, except in emergencies, may not be accessible to anyone without the written consent of the participant or if a court orders disclosure other than the following:

(1) The participant.

(2) The participant's legal guardian.

(3) The provider staff for the purpose of providing a service to the participant.

(4) An agent of the Department.

(5) An individual holding the participant's power of attorney for health care or health care proxy.

§ 52.30. Waiver of a program qualification.

(a) The Department may grant a waiver to a provision of this chapter which is not otherwise required by Federal and State law and does not jeopardize the health, safety or well-being of a participant.

(b) The waiver request must be on a form prescribed by the Department.

Subchapter C. PAYMENT FOR SERVICES

Sec.

VENDOR GOOD OR SERVICE

GENERAL REQUIREMENTS

§ 52.41. Provider billing.

(a) A provider shall submit claims in accordance with § 1101.68 (relating to invoicing for services).

(b) A provider shall use the Department's designated claims processing system to submit claims.

(c) An applicant may not bill for a service prior to being enrolled as a provider by the Department.

(d) The provider shall enroll in the Department's designated claims processing system upon receiving notice that the application is approved.

§ 52.42. Payment policies.

(a) Services will be paid as either a fee schedule service under § 52.45 (relating to fee schedule rates) or as a vendor good or service payment under § 52.51 (relating to vendor good or service payment).

(b) The Department will publish services specific to each waiver and the Act 150 program as a notice in the *Pennsylvania Bulletin*.

(c) The Department will only pay for a service in accordance with this chapter and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies).

(d) The Department will only pay for a service in the type, scope, amount, duration and frequency as specified on the participant's service plan as approved by the Department.

(e) A provider who accepts supplementary payment for an Act 150 service from a source other than the Department shall return the Act 150 payment to the Department. If the supplementary payment pays only a portion of the cost of the Act 150 service, the provider shall return an amount equal to the supplementary payment to the Department. This subsection does not apply to copayments.

(f) The Department will recoup payments which are not made in accordance with this chapter.

(g) The Department may limit the type of service available in accordance with Federal and State laws, the waiver program requirements or Act 150 program requirements.

(h) The Department will not reimburse a provider who renders a service to a participant who does not have an approved service plan for the date when the service was rendered.

(i) To be paid the MA Program fee schedule rate or receive reimbursement for a vendor good or service, a provider shall comply with this chapter.

(j) The Department will not pay for a service which is rendered to a participant who is enrolled in a waiver or the Act 150 program that does not include the service.

§ 52.43. Audit requirements.

(a) A provider shall comply with Federal audit requirements including the following:

(1) The Single Audit Act of 1984 (31 U.S.C.A. § § 7501—7507).

(2) The revised Office of Management and Budget Circular A-133.

(3) Section 74.26 of 45 CFR (relating to non-Federal audits).

(b) A provider which is required to receive a single audit or an audit in accordance with 45 CFR 74.26 shall comply with the audit requirements.

(c) The Department may request a provider to have the provider's auditor perform an attestation engagement in accordance with any of the following:

(1) Government Auditing Standards issued by the Comptroller General of the United States or the Generally Accepted Government Auditing Standards.

(2) Standards issued by the Auditing Standards Board.

(3) Standards issued by the American Institute of Certified Public Accountants.

(4) Standards issued by the International Auditing and Assurance Standards Board.

(5) Standards issued by the Public Company Accounting Oversight Board.

(6) Standards of successor organizations to those organizations in paragraphs (1)—(5).

(d) The Department or the Department's designee may perform an attestation engagement in accordance with subsection (c).

(e) The Department may request the provider's auditor to conduct a performance audit in accordance with the standards in subsection (c).

(f) A provider which is not required to have an attestation agreement in compliance with the Single Audit Act of 1984 during the program year shall maintain auditable records in compliance with this section.

(g) The Department may perform a financial review of a provider.

(h) A provider shall maintain books, records and documents that support:

(1) The type, scope, amount, duration and frequency of service provision.

(2) The dates of service provision.

(3) The fees and reimbursements earned in accordance with Federal and State requirements.

(4) Compliance with the terms and conditions of service provision as outlined in this chapter.

(i) Electronic records are acceptable documentation provided they comply with § 52.15 (relating to provider records) and electronic records are accessible to the auditing agency.

(j) A provider shall make audit documentation available, upon request, to the authorized representatives of the Department or the Department's designee.

(k) A provider shall retain books, records and documents for inspection, audit or reproduction for at least 5 years after the provider's fiscal year-end.

(l) The provider shall retain books, records and documents related to the fiscal year for a time period greater than 5 years from the provider's fiscal year-end if one of the following is applicable:

(1) The Department, Department's designee or another State or Federal agency has unresolved questions regarding costs or activities.

(2) The books, records or documents are part of an ongoing investigation or legal action.

(3) Required by applicable State or Federal law.

(m) If a provider is completely or partially terminated, the records relating to the services terminated shall be preserved and made available for at least 5 years from the date of a resulting final settlement or termination of provider, whichever is longer.

(n) A provider shall retain records that relate to litigation of the settlement of claims arising out of performance or expenditures under a waiver or the Act 150 program to which an auditor has taken exception, until the litigation, claim or exceptions have reached final disposition or for a period of at least 5 years from the provider's fiscal year-end, whichever is greater.

(o) The provider shall provide information listed under this section to the Department or Department's designee upon request.

§ 52.44. Reporting requirements for ownership change.

(a) A provider assuming ownership shall report a change in ownership or control interest of 5% or more in writing to the Department at least 30 days prior to the effective date of the change.

(b) If the provider is unable to report an ownership or controlling interest change at least 30 days prior to the effective date of the change because of an emergency, then the provider shall report the change as soon as possible, but no later than 2 business days after the effective date of the change. The provider shall also inform the Department as to why the provider was unable to report the change 30 days prior to the change's occurrence.

(c) The provider assuming ownership shall report the following:

(1) Effective date of sale or controlling interest change.

(2) A copy of the sales agreement or other document effectuating the change.

(d) If a provider fails to notify the Department as specified in subsections (a)—(c), the provider shall forfeit payments for each day after the notice was due to the Department.

§ 52.45. Fee schedule rates.

(a) The Department will establish a fee schedule rate for a waiver or Act 150 program service.

(b) The Department will publish the fee schedule rate under the MA Program fee schedule as a notice in the *Pennsylvania Bulletin*.

(c) The Department will publish a change in the methods and standards for setting a fee schedule rate as a notice in the *Pennsylvania Bulletin*.

(d) The Department will publish the services specific to each waiver and the Act 150 program as a notice in the *Pennsylvania Bulletin*.

Cross References

This section cited in 55 Pa. Code § 52.42 (relating to payment policies).

VENDOR GOOD OR SERVICE

§ 52.51. Vendor good or service payment.

(a) The Department will only pay for the actual cost of a vendor good or service which may not exceed the amount for a similar vendor good or service charged to the general public.

(b) A provider shall retain documentation of the amount charged for the vendor good or service.

(c) The provider shall submit verification of subsection (b) to the Department upon request.

(d) The Department will publish the list of vendor goods or services as a notice in the *Pennsylvania Bulletin*.

(e) The Department will publish the list of vendor goods or services specific to each waiver or the Act 150 program as a notice in the *Pennsylvania Bulletin*.

Cross References

This section cited in 55 Pa. Code § 52.42 (relating to payment policies); and 55 Pa. Code § 52.52 (relating to subcontracting for a vendor good or service).

§ 52.52. Subcontracting for a vendor good or service.

(a) Only an OHCDS may subcontract with an entity to purchase a vendor good or service. A provider who subcontracts shall have a written agreement specifying its duties, responsibilities and compensation.

(b) Only a vendor good or service may be subcontracted.

(c) If an OHCDS subcontracts with an entity to provide a vendor good or service, the OHCDS shall ensure the entity complies with § 52.51(a) (relating to vendor good or service payment).

(d) The Department will not pay an administrative fee or additional cost for a vendor good or service subcontracted by an OHCDS.

§ 52.53. Organized health care delivery system.

(a) An OHCDS shall be an SCE in compliance with this chapter.

(b) An OHCDS may not be reimbursed for rendering service coordination services if it contracts with an entity which is listed on the LEIE, EPLS or Medicheck list.

(c) An OHCDS may not be reimbursed for rendering service coordination services if the OHCDS contracts with an entity which employs a person who is listed on the LEIE or EPLS.

(d) An OHCDS shall complete and sign an OHCDS enrollment form.

Cross References

This section cited in 55 Pa. Code § 52.28 (relating to conflict free service coordination).

Subchapter D. PROVIDER DISQUALIFICATION

Sec.

§ 52.61. Provider cessation of services.

(a) If a provider is no longer able or willing to provide services, the provider shall perform the following:

(1) Send written notification to each participant, the Department and other providers with which the provider works that the provider is ceasing services at least 30 days prior to the provider ceasing services.

(2) Notify licensing or certifying entities as required.

(3) Send the Department a copy of the notification sent to a participant and service providers as required under paragraph (1). If the provider uses a general notification for all participants or service providers, a single copy of the notification is acceptable.

(4) Cooperate with the Department, new providers of services and participants with transition planning to ensure the participant's continuity of care.

(b) If the provider fails to notify the Department as specified in subsection (a), the provider shall forfeit payment for each day that the notice is overdue until the notice is issued.

§ 52.62. Prohibition of services.

(a) A provider may be sanctioned, prohibited or disenrolled from providing services for failure to perform any of the following:

(1) Protect the health and welfare of a participant during service delivery.

(2) Comply with applicable Federal or State laws and this chapter.

(3) Comply with a provision of the MA provider agreement, including the waiver addendum.

(4) Deliver a service in the type, scope, amount, duration and frequency required by the approved service plan when the participant is available for the delivery of the service.

(5) Develop or implement a CAP.

(6) Maintain licenses or certifications, or both, as required by Federal or State agencies.

(7) Maintain accurate records.

(b) The Department may prohibit a provider from providing new participants with services if the provider violates subsection (a).

(c) A disenrolled provider shall cooperate with the Department, new providers of services and participants with transition planning to ensure participant's continuity of care.

§ 52.63. Provider misutilization and abuse.

(a) If the Department's audit, financial review or monitoring indicates that a provider has been billing for services in a manner inconsistent with this chapter, unnecessary or inappropriate to a participant's needs, or contrary to customary standards of practice, the Department will notify the provider in writing that payment on all invoices will be delayed or suspended for a period not to exceed 120 days pending a review of billing and service patterns.

(b) A provider may have its invoices reviewed prior to payment.

(c) A provider's records may be reviewed.

(d) A provider may be required to submit a written explanation of billing practices.

§ 52.64. Payment sanctions.

(a) If the provider fails to submit an acceptable attestation engagement or pass a financial review, in accordance with this chapter, the Department may initiate sanctions against the provider including the following:

(1) Disallowing all or a portion of a payment.

(2) Suspending a current or future payment pending compliance.

(3) Recouping a payment for a service the provider cannot verify as being provided in the amount, duration and frequency billed.

(b) If a provider does not comply with this chapter or other State or Federal requirements, the Department may initiate the sanctions under subsection (a).

§ 52.65. Appeals.

A provider may file an appeal of a Departmental action in accordance Chapters 41 and 1101 (relating to Medical Assistance provider appeal procedures; and general provisions).

CHAPTER THIRTEEN

§ 1101.51. Ongoing responsibilities of providers. (includes conflict free)

(a) *Recipient freedom of choice of providers.* A recipient may obtain services from any institution, agency, pharmacy, person or organization that is approved by the Department to provide them. Therefore, the provider shall not make any direct or indirect referral arrangements between practitioners and other providers of medical services or supplies but may recommend the services of another provider or practitioner; automatic referrals between providers are, however, prohibited.

(b) *Nondiscrimination.* Federal regulations require that programs receiving Federal assistance through HHS comply fully with Title VI of the Civil Rights Act of 1964 (42 U.S.C.A. § § 2000d—2000d-4), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.A. § 794), and the Pennsylvania Human Relations Act (43 P. S. § § 951—963). Providers are prohibited from denying services or otherwise discriminating against an MA recipient on the grounds of race, color, national origin or handicap.

(c) *Interrelationship of providers.* Providers are prohibited from making the following arrangements with other providers:

(1) The referral of MA recipients directly or indirectly to other practitioners or providers for financial consideration or the solicitation of MA recipients from other providers.

(2) The offering of, or paying, or the acceptance of remuneration to or from other providers for the referral of MA recipients for services or supplies under the MA Program.

(3) A participating provider may not lease or rent space, shelves or equipment within a provider's office to another provider or allowing the placement of paid or unpaid staff of another provider in a provider's office. This does not preclude a provider from owning or investing in a building in which space is leased for adequate and fair consideration to other providers nor does it prohibit an ophthalmologist or optometrist from providing space to an optician in his office.

(4) The solicitation or receipt or offer of a kickback, payment, gift, bribe or rebate for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering a good, facility, service or item for which payment is made under MA. This does not preclude discounts or other reductions in charges by a provider to a practitioner for services, that is, laboratory and x-ray, so long as the price is properly disclosed and appropriately reflected in the costs claimed or charges made by a practitioner.

(5) A participating practitioner or professional corporation may not refer a MA recipient to an independent laboratory, pharmacy, radiology or other ancillary medical service in which the practitioner or professional corporation has an ownership interest.

(d) *Standards of practice.* In addition to licensing standards, every practitioner providing medical care to MA recipients is required to adhere to the basic standards of practice listed in this subsection. Payment will not be made when the Department's review of a practitioner's medical records reveals instances where these standards have not been met.

(1) A proper record shall be maintained for each patient. This record shall contain, at a minimum, all of the following:

(i) A complete medical history of the patient.

(ii) The patient's complaints accompanied by the findings of a physical examination.

(iii) The information set forth in subsection (e)(1).

(2) A diagnosis, provisional or final, shall be reasonably based on the history and physical examination.

(3) Treatment, including prescribed drugs, shall be appropriate to the diagnosis.

(4) Diagnostic procedures and laboratory tests ordered shall be appropriate to confirm or establish the diagnosis.

(5) Consultations ordered shall be relevant to findings in the history, physical examination or laboratory studies.

(6) The principles of medical ethics shall be adhered to.

(e) *Record keeping requirements and onsite access.* Providers shall retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA recipients and that meet the criteria established in this section and additional requirements established in the provider regulations. Providers shall make those records readily available for review and copying by State and Federal officials or their authorized agents. Readily available means that the records shall be made available at the provider's place of business or, upon written request, shall be forwarded, without charge, to the Department. Providers who are subject to an annual audit shall submit their cost reports within 90 days following the close of their fiscal years. If the Department terminates its written agreement with a provider, the records relating to services rendered up to the effective date of the termination remain subject to the requirements in this section.

(1) *General standards for medical records.* A provider, with the exception of pharmacies, laboratories, ambulance services and suppliers of medical goods and equipment shall keep patient records that meet all of the following standards:

(i) The record shall be legible throughout.

(ii) The record shall identify the patient on each page.

(iii) Entries shall be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel shall be countersigned by the responsible licensed provider. Alterations of the record shall be signed and dated.

(iv) The record shall contain a preliminary working diagnosis as well as a final diagnosis and the elements of a history and physical examination upon which the diagnosis is based.

(v) Treatments as well as the treatment plan shall be entered in the record. Drugs prescribed as part of the treatment, including the quantities and dosages shall be entered in the record. If a prescription is telephoned to a pharmacist, the prescriber's record shall have a notation to this effect.

(vi) The record shall indicate the progress at each visit, change in diagnosis, change in treatment and response to treatment.

(vii) The record shall contain summaries of hospitalizations and reports of operative procedures and excised tissues.

(viii) The record shall contain the results, including interpretations of diagnostic tests and reports of consultations.

(ix) The disposition of the case shall be entered in the record.

(x) The record shall contain documentation of the medical necessity of a rendered, ordered or prescribed service.

(2) *Fiscal records.* Providers shall retain fiscal records relating to services they have rendered to MA recipients regardless of whether the records have been produced manually or by computer. This may include, but is not necessarily limited to, purchase invoices, prescriptions, the pricing system used for services rendered to patients who are not on MA, either the originals or copies of Departmental invoices and records of payments made by other third party payors.

(3) *Additional record keeping requirements for providers in a shared health facility.* In addition to the record keeping and access requirements specified in this subsection, practitioners

and purveyors in a shared health facility shall meet § 1102.61 (relating to inspection by the Department).

(4) *Penalties for noncompliance.* The Department may terminate its written agreement with a provider for noncompliance with the record keeping requirements of this chapter or for noncompliance with other record keeping requirements imposed by applicable Federal and State statutes and regulations.

Appendices

Appendix A OLTL Bulletins

http://www.dhs.pa.gov/publications/bulletinsearch/bulletinsearchresults/index.htm?po=OLTL

Appendix B OLTL Information for Providers

http://www.dpw.state.pa.us/dpworganization/officeoflongtermliving/providers/index.htm

Above weblink includes PDF link to DPW Provider Manual February 2014