DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations

SWIFT #061020154027

June 22, 2016

Nancy Thaler, Deputy Secretary
Department of Human Services
Office of Developmental Programs
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Dear Ms. Thaler:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) quality assessment review of the Pennsylvania Person Family Support Directed Waiver, CMS control number 0354 This waiver serves individuals age three and older who have a diagnosis of an intellectual disability, require active treatment, and meet intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care.

The waiver, authorized under the provisions of 1915(c) of the Social Security Act, provides the following home and community-based services: Education Support Services; Home and Community Habilitation (Unlicensed); Homemaker/Chore, Licensed Day Habilitation, Prevocational Services, Residential Habilitation, Respite, Supported Employment - Job Finding and Job Support, Supports Coordination, Nursing, Therapy Services, Supports Broker Services, Assistive Technology, Behavioral Support, Companion, Home Accessibility Adaptations, Specialized Supplies, Transitional Work Services, Transportation, and Vehicle Accessibility Adaptations.

The report identifies the findings for each assurance, the evidence supporting our conclusions, and recommendations. Pertinent information from Pennsylvania's response to the draft report's recommendations has been incorporated into the final report.

CMS found the State to be in compliance with the following assurances:

State Conducts Level of Care Determinations Consistent with the Need for Institutionalization
Service Plans are Responsive to Waiver Participant Needs
Qualified Providers Serve Waiver Participants
Health and Welfare of Waiver Participants
State Medicaid Agency Retains Administrative Authority over the Waiver Program
State Provides Financial Accountability for the Waiver

The final waiver assessment report is releasable to the public.

Finally, we would like to remind you to submit the renewal package for this waiver to the CMS Central and Regional Offices at least 90 days prior to the expiration of the waiver on June 30, 2017.

We want to extend our sincere appreciation to the Office of Developmental Program staff who assisted in the process and provided information for this review. If you have any questions, please contact Talbatha Myatt at (215) 861-4259.

Sincerely,

Francis T. Mccullough -S

Digitally signed by Francis T. Mccullough -S
Date: 2016.06.22 16:35:21 -04'00'

Francis McCullough
Associate Regional Administrator

Enclosure

cc: Nancy Thaler, ODP (electronic copy)
Julie Mochon, ODP (electronic copy)
Daphne Hicks, CMCS (electronic copy)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region III

FINAL QUALITY REVIEW REPORT

Home and Community-Based Services Waiver Review
Commonwealth of Pennsylvania Person/Family Directed Support Waiver
Control # 0354
June 22, 2016

Home and Community-Based Services
Waiver Review Report

Executive Summary:

The Commonwealth of Pennsylvania's The Pennsylvania Person/Family Directed Support Waiver (P/FDS) is designed to help individuals with an intellectual disability live more independently in their homes and communities and to provide a variety of services that promote community living, including self-directed service models and traditional, agency-based service models. Individuals served by this Waiver must be age three and older, have a diagnosis of an intellectual disability, require active treatment, be recommended for an Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/ID) level of care based on medical evaluation, be determined eligible for Medical Assistance. A $30,000 per person per fiscal year total limit is established for all P/FDS Waiver services, with the exception of Supports Coordination." The latest CMS 372 Report, for the waiver year ending June 30, 2013, indicated that the Waiver served 11,705 individuals at an average annual per capita cost of $16,417.

The Centers for Medicare & Medicaid Services (CMS) approved the P/FDS Waiver for renewal of a five-year term effective July 1, 2012. This report contains a quality review of the first three years of the renewal period, from July 2012 through June 2015. These three years coincide with State Fiscal Years (SFY), and data are presented by SFY throughout the report. The Department of Human Services (Department), as the State Medicaid agency, retains authority over the administration and implementation of the P/FDS Waiver. The Office of Developmental Programs (ODP), as part of the State Medicaid Agency, is responsible for the development and distribution of policies, procedures, and rules related to Waiver operations. An Administrative Entity (AE) is a County Mental Health/Intellectual Disability (MH/ID) Program or a non-governmental entity with a signed agreement with ODP to perform operational and administrative functions delegated by ODP related to the approved P/FDS Waiver. The AE Operating Agreement establishes the roles and responsibilities of AEs with respect to functions delegated to them for program administration.

The Centers for Medicare & Medicaid Services (CMS) conducted the current review of the waiver program in accordance to 42 CFR 441.302 and instructions in the May 28, 2004 (and February 6, 2007 update) Interim Procedural Guidance. We requested the Commonwealth of Pennsylvania to provide evidence to CMS to substantiate that the waiver is being administered in accordance with the terms of the approved Section 1915(c) waiver and that the specified assurances are met. The review was completed via a desk review of the materials submitted and ongoing communication with the ODP.

The CMS completed the review of information provided by the Commonwealth of Pennsylvania Office of Developmental Programs. It was determined that the evidence submitted demonstrates that the Commonwealth of Pennsylvania substantially meets the assurances to administer the waiver.

The current waiver expires on June 30, 2017. The renewal for the Person/Family Directed Support Waiver is due to CMS by April 1, 2017.

The report findings for each assurance are as follows:

I.State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The state substantially meets the assurance.

II.Service Plans are Responsive to Waiver Participant Needs

The state substantially meets the assurance.

III.Qualified Providers Serve Waiver Participants

The state substantially meets the assurance.

IV. Health and Welfare of Waiver Participants

The state substantially meets the assurance.

V.State Medicaid Agency Retains Administrative Authority over the Waiver Program

The state substantially meets the assurance.

VI.State Provides Financial Accountability for the Waiver

The state substantially meets the assurance.

Introduction:

Pursuant to §1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a state to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve state HCBS waiver programs.

CMS must assess each home and community based waiver program in order to determine that state assurances are met. This assessment also serves to inform CMS in its review of the state's request to renew the waiver.

State Waiver Name:	Person/Family Directed Support Waiver
Operating Agency:	Office of Developmental Programs (ODP)
State Waiver Contact:	Julie Mochon, MSW, Policy Supervisor Department of Human Services (717)783-5771
Target Population:	Individuals with Intellectual Disabilities
Level of Care:	Intermediate Care Facility/Intellectual Disability (ICF/ID)
Number of Waiver Participants:	11,705 reported for waiver year ending June 30, 2013
Average Annual Per Capita Costs:	$16,417 reported for waiver year ending June 30, 2013
Effective Dates of Waiver:	July 1, 2012-June 30, 2017
Approved Waiver Services:	The waiver, authorized under the provisions of 1915(c) of the Social Security Act, provides the following home and community-based services: Education Support Services; Home and Community Habilitation (Unlicensed); Homemaker/Chore; Licensed Day Habilitation; Prevocational Services; Respite; Supported Employment - Job Finding and Job Support; Supports Coordination; Nursing Services; Therapy Services; Supports Broker Services; Assistive Technology; Behavioral Support; Companion; Home Accessibility Adaptations; Specialized Supplies; Transitional Work Services; Transportation; Vehicle Accessibility Adaptations
CMS Contact:	Talbatha Myatt, MHSA, MPA Health Insurance Specialist; 215-861-4259

I. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The state must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/ID-DD. *Authority: 42 CFR 441.301; 42 CFR 441.302; 42 C'FR 441.303; SMM 4442.5*

The State substantially meets the assurance.

Level of Care Subassurance A - An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Table 2.1 Performance Measure LOC.a.i.a.1.

Performance Measure: Number and percent of new enrollees who have an evaluation for LOC completed prior to entry into the waiver. (Data Source: HCSIS)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of new enrollees who have an evaluation for LOC completed prior to entry into the waiver.*	N	1,468	1,706	1,556
Denominator = *Number of new enrollees.*	D	1.470	1,707	1,558
	% (N/D)	99%	99%	99%
REMEDIATION DATA				
Noncompliant		2	1	2
Evaluation completed after entry into the waiver		2	1	2
Remediated within 30 days		2	1	2
# Remediated		2	1	2
% Remediated		100%	100%	100%

Details: ODP generates and distributes to the specific AE, HCSIS reports identifying initial level of care (LOC) compliance and noncompliance data. The reports include a list of exceptions for that AE (any individual for whom a level of care evaluation is not entered into HCSIS as completed prior to the Waiver start date). The AE is responsible to review these reports and provide remediation for any situation where a LOC has not been completed prior to Waiver enrollment. Remediation will include completion of LOC documents and/or data entered into HCSIS. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

On a monthly basis, ODP generates a 100% sample report of all P/FDS Waiver initial enrollees. ODP reviews for any exceptions (any individual for whom a level of care evaluation is not entered into HCSIS as completed prior to the waiver start date) and conducts follow-up activities with the specific AE. The process of providing feedback is contingent on the factors of the non-compliance. ODP provides guidance and technical assistance as necessary. ODP verifies completion of LOC documents and/or that data has been entered into HCSIS and also assures that the AE has established policies and procedures to prevent a recurrence.

The variance of new enrollees is dependent on turnover capacity as well as the Governor's budget initiatives to support additional capacity in the P/FDS Waiver. For example, in FY13-14 ODP received funding to support 700 additional capacity in the P/FDS Waiver in order to serve 2013 graduates.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates that the sub-assurance has been met.

Level of Care Subassurance B - The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Table 2.2 Performance Measure LOC.a.i.b.1.

Performance Measure: Number and percent of annual LOC determinations completed within 365 days of the prior review. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of LOC redeterminations completed within 365 days of prior review.*	N	232	249	232
Denominator = *Number of LOC redeterminations that are due.*	D	298	286	269
	% (N/D)	78%	87%	86%
Number of annual LOC redeterminations complete late		63	25	23
Within 30 days		51	19	18
Within 31 – 60 days		2	2	3
Within 61 – 90 days		1	2	0
In greater than 90 days		9	2	2
Number compliant before remediation		295	274	255
% compliant before remediation		99%	96%	95%

REMEDIATION DATA			
Noncompliant requiring remediation	3	12	14
Remediated by locating missing documentation	1	0	11
Remediated by completing LOC determinations which included both legible signatures and dates	2	10	2
Participant terminated prior to redetermination	0	2	1
Remediated within 30 days	3	2	12
Remediated within 31-60 days	0	3	1
Remediated within 61-90 days	0	7	0
Remediated in >90 days	0	0	1
# Remediated	3	12	14
% Remediated	100%	100%	100%

Details: As part of the AEOMP record review, ODP evaluates whether annual LOC redeterminations are completed within 365 days of the prior review. AEs must locate or complete LOC evaluations using ODP's standardized forms and process. AEs must enter the LOC redetermination date into HCSIS. ODP sends a letter to the waiver participant upon completion of their LOC determination/redetermination. If there is a change in the LOC redetermination, the letter explains the reasons that led to the change and provides fair hearing and appeal rights along with a resource for the participant/family to call in case they have questions. AEs are expected to document remediation actions and submit the documentation to ODP within 30 days of the notification.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates that the sub-assurance has been met.

Level of Care Sub-assurance C - The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Table 2.3 Performance Measure LOC.a.i.c.1.

Performance Measure: Number and percent of LOC initial determinations and redeterminations completed according to ODP policies and procedures. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of LOC initial determinations and redeterminations completed according to ODP policies and procedures.*	N	304	290	302
Denominator = *Number of LOC determinations and redeterminations reviewed*	D	310	314	314
	% (N/D)	98%	93%	96%
REMEDIATION DATA				
Noncompliant		6	23	12
Missing documentation was located		0	2	7
LOC redetermination form was created and includes both legible signatures and dates		2	1	1
LOC form was corrected and includes both legible signatures and dates.		2	7	1
QIDP credentials verified/determinations accepted		0	13	0
Physical was conducted to complete redetermination		1	0	0
Participant disenrolled		1	0	3
Remediated within 30 days		6	14	11
Remediated within 31-60 days		0	2	1
Remediated within 61-90 days		0	7	0
# Remediation		6	23	12
% Remediated		100%	100%	100%

Details: ODP evaluates whether initial LOC determinations and annual LOC redeterminations are completed according to ODP policies and procedures. AEs must locate or complete LOC evaluations using ODP's standardized forms and process in cases where the documentation is not present during the onsite review. AEs are expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

Table 2.4 Performance Measure LOC.a.i.c.2.

Performance Measure: Number and percent of initial LOC determinations and redeterminations that were completed accurately. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of initial LOC determinations and redeterminations that were completed accurately.*	N	295	297	290
Denominator = *Number of LOC determinations and redeterminations reviewed.*	D	310	313	314
	% (N/D)	95%	95%	92%
REMEDIATION DATA				
Noncompliant		15	16	24
Missing documentation of standardized adaptive assessments was located		8	4	11
Medical evaluations were completed and include a recommendation for ICF/ID LOC		4	12	8
Staff/Supports Coordinator Retrained		1	0	2
Participant disenrolled		2	0	3
Remediated within 30 days		12	6	20
Remediated within 31 – 60 days		2	3	2
Remediated within 61 – 90 days		1	7	0
In greater than 90 days		0	0	2
# Remediated		15	16	24
% Remediated		100%	100%	100%

Details: ODP evaluates whether initial LOC determinations and annual LOC redeterminations are completed accurately. AEs are required to locate or complete required documentation that is not present or does not contain the necessary information during the onsite review, including the medical evaluation that documents a recommendation for ICF/ID LOC, a psychological evaluation that contains the results of a standardized general intelligence test that certifies the individual has a diagnosis of intellectual disability/significantly sub-average intellectual functioning, a Standardized Adaptive Assessment indicating impairments in adaptive behavior, and documentation that the individual had conditions of intellectual and adaptive functioning manifested during the developmental period which is from birth up to the individual's 22nd birthday. AEs are expected to document the remediation actions and submit the documentation to ODP within 30 days.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates that the sub-assurance has been met.

II. Service Plans are Responsive to Waiver Participant Needs

The state must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7 Section 1915(c) Waiver Format, Item Number 13

The State substantially meets the assurance.

Service Plan Subassurance a: Service plans address all participants' assessed needs (including health and welfare risk factors) and personal goals, either by the provision of waiver services or through other means.

Table 4.1 Performance Measure SP.a.i.a.1.

Performance Measure: Number and % of waiver participants who have all assessed needs addressed in the ISP through waiver funded services or other funding sources or natural supports. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of participants who have all assessed needs addressed in the ISP through waiver funded services or other funding sources or natural supports.*	N	282	309	296
Denominator = *Number of waiver participants reviewed.*	D	311	314	314
	% (N/D)	91%	98%	94%
REMEDIATION DATA				
Noncompliant		29	5	18
ISP was amended to reflect all assessed needs		26	5	16
PUNS reflects a change in need		1	0	0
PUNS not needed		1	0	0
Participant moved out of state		1	0	0
Participant deceased		0	0	1
Staff retrained		0	0	1
Remediated within 30 days		23	3	0
Remediated within 31-60 days		6	1	0
Remediated within 61-90 days		0	1	0
# Remediated		29	5	18
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if participants have all assessed needs addressed in their ISPs through Waiver funded services or other funding sources or natural supports. If a participant's plan does not contain evidence that all assessed needs have been reviewed and/or addressed by the participant and his/her team, the AE will work with the SCO to ensure that the ISP is revised to support the identified assessed needs.

If an ISP does not address all the participant's assessed needs, the Supports Coordinator (SC) is responsible for coordinating with the participant, his/her family and other team members to gather the missing information. If a change in waiver services occurs as a result of the team meeting, the ISP Signature Form is signed and the date the meeting occurred is documented. When revisions are completed and the ISP is approved and authorized, the SC is responsible for sharing the revised ISP with the participant and his/her family.

The AE will provide ODP with the ISP approval date that reflects the changes made to the ISP that correct the identified noncompliance. Remediation by the AE is expected within 30 days of notification.

Table 4.2 Performance Measure SP.a.i.a.2.

Performance Measure: Number and % of waiver participants who have had a risk assessment and services and supports in the ISP to mitigate the risk where appropriate. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants who have had a risk assessment.* ***Denominator =*** *Number of waiver participants reviewed.*	N	311	314	314
	D	311	314	314
	% (N/D)	100%	100%	100%
Numerator (N) = *Number of waiver participants who have had services and supports in the ISP to mitigate risk where appropriate.* ***Denominator =*** *Number of waiver participants reviewed.*	N	304	304	299
	D	310	310	313
	% (N/D)	98%	98%	96%
Number noncompliant		6	6	14
Risk mitigation strategies are included in the ISP		5	6	12
Participant disenrolled from waiver		0	0	1
Service referral made		0	0	1
Participant moved out of Pennsylvania		1	0	0
Remediated within 30 days		6	3	12
Remediated within 31-60 days		0	1	1
Remediated within 61 – 90 days		0	2	0
# Remediated		6	6	14
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if the required risk assessment has been completed for each participant and that services and supports are included in the ISP to mitigate the identified risk where appropriate. If there is no evidence in the participant's record that a risk assessment has been completed, the applicable AE and SCO will work together to ensure completion and documentation in the ISP of the risk assessment.

If a participant's record does not contain evidence that services and supports have been incorporated in the ISP that mitigate a participant's identified risks, the AE will work with the SCO to ensure that the ISP is amended to include risk mitigation strategies. The AE will notify ODP of the date that the changes were made to the ISP correcting the identified noncompliance. Remediation by the AE is expected within 30 days of notification. This measure looks separately to assure completion of a risk assessment and to assure risk mitigation.

If an ISP does not include risk mitigation strategies, the SC is responsible for coordinating with the participant, his/her family and other team members to gather the missing information. If a change in waiver services occurs as a result of the team meeting, the ISP Signature Form is signed and the date the meeting occurred is documented. When revisions are completed and the ISP is approved and authorized, the SC is responsible for sharing the revised ISP with the participant and his/her family.

Table 4.3 Performance Measure SP.a.i.a.3.

Performance Measure: Number and % of waiver participants whose ISPs reflect their personal goals. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants whose ISPs reflect their personal goals.*	N	283	299	296
Denominator = *Number of waiver participants reviewed.*	D	311	314	314
	% (N/D)	91%	95%	94%
REMEDIATION DATA				
Noncompliant		28	15	18
ISPs amended to reflect outcomes that relate to an identified preference		27	15	17
Participant is SCO only and no longer has an ISP		1	0	0
Participant disenrolled from waiver		0	0	1
Remediated within 30 days		24	7	10
Remediated within 31-60 days		2	4	1
Remediated within 61-90 days		2	0	2
Remediated in >90 days		0	4	4
# Remediated		28	15	18
% Remediated		100	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if they reflect participants identified personal goals by reviewing relevant sections of the ISP. If there is no evidence in an ISP that a participant's identified personal goals have been incorporated, the applicable AE and SCO will work together to ensure that the ISP is amended to include language that reflects the individuals identified personal goals. In the event an ISP did not identify the participant's personal goals, the SC is responsible for coordinating with the participant, his/her family and other team members to gather the missing information.

If a change in waiver service occurs as a result of the team meeting, the ISP Signature Form is signed and the date the meeting occurred is documented. When revisions are completed and the ISP is approved and authorized, the SC is responsible for sharing the revised ISP with the participant and his/her family. The AE will notify ODP of the date that the changes were made to the ISP correcting the identified noncompliance. Remediation by the AE is expected within 30 days of notification.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates that the sub-assurance has been met

Service Plan Subassurance b - The State monitors service plan development in accordance with its policies and procedures.

Table 4.4 Performance Measure SP.a.i.b.1.

Performance Measure: Number and % of ISPs that are developed consistent with state policies and procedures as described in the approved waiver. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of ISPs that are developed consistent with state policies and procedures as described in the approved waiver.* ***Denominator =*** *Number of waiver participants reviewed.*	N	301	304	298
	D	311	314	314
	% (N/D)	97%	97%	95%
REMEDIATION DATA				
Noncompliant		10	10	16
The ISP was reviewed with the consumer		4	6	15
ODP expectations reviewed with waiver provider		6	4	1
Remediated within 30 days		8	5	12
Remediated within 31-60 days		1	1	4
Remediated in >90 days		1	4	0
Not remediated; referred to appropriate staff for follow-up		0	0	0
# Remediated		10	10	16
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if ISPs are developed consistently with the State policies/procedures and the ISP Bulletin. ODP will determine if specific criteria have been included in the ISP with remediation expected by AEs when deficiencies in the record are noted. There are six aspects of policy which are evaluated. They include: individual attended the ISP meeting; team members attended the ISP meeting; ISPs where service frequency is indicated; ISPs that include all service and supports; services authorized consistent with service definitions; and AE authorized qualified providers.

Remediation strategies are developed specific to each performance area to ensure ongoing compliance with ODP's policy and procedures. The following table identifies remediation strategies for each of the six aspects of policy that are evaluated to inform this particular performance measure:

Policy	Remediation Strategy
1. The waiver participant attended the ISP meeting.	• The ISP was reviewed with the participant.
2. The required team members attended the ISP meeting.	• ODP expectation regarding attendance at the participant's ISP is communicated to waiver provider or providers.
3. Service frequency is indicated in the ISP.	• The ISP is amended to include frequency within 21 days.
4. Were all services and supports in the approved ISP?	• The ISP is amended as appropriate to include all services and supports within 21 days.
5. The AE authorizes services consistent with the service definitions.	• Service provided meets service definition and ISP amended by a critical revision within 21 days.
6. The AE authorized qualified provider(s) to deliver all services authorized in the ISP.	• All Services authorized are provided by qualified providers and ISP is amended as appropriate.

Through the AE Oversight Monitoring database, ODP provides these suggested remediation actions for the AE's consideration. The AE and SCO can work together to complete one of the suggested remediation actions or propose another appropriate remediation action for ODP's consideration. Other remediation actions are developed by the AE specific to the unique needs of the participant. Other remediation actions have included training staff, making updates to documents other than the ISP, and choosing a new provider.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates that the sub-assurance has been met.

Service Planning Subassurance c - Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Table 4.5 Performance Measure SP.a.i.c.1.

Performance Measure: Number and % of waiver participants whose Annual ISPs were reviewed/ revised and approved within 365 days of the prior Annual ISP. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants whose Annual ISPs were reviewed/revised and approved within 365 days of the prior Annual ISP update date.* ***Denominator =*** *Number of waiver participants reviewed.*	N	268	300	293
	D	292	311	312
	% (N/D)	92%	96%	94%
Number of annual ISPs reviewed and/or approved late		24	11	19
Within 30 days		14	6	9
Within 31 – 60 days		3	2	8
Within 61 – 90 days		1	2	2
In greater than 90 days		6	1	0
Number compliant before remediation		292	311	312
% compliance before remediation		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records that identify any participants for whom annual ISPs are not approved within 365 days of the prior annual ISP. If there is no evidence in a record that the ISP was completed and approved, and that services were authorized by the annual review update date, the applicable AE and SCO will work together to ensure the ISP is completed within 30 days of notification. While not all ISPs are being updated within 365 days, providers and stakeholders are aware of ODP's expectation and are demonstrating at the time of on-site review that ISPs have been updated, with no remediation required.

ODP expects ISPs to be updated within 365 days. It is possible that an Annual ISP was not completed within 365 days of the prior Annual ISP but was completed before the AEOM review occurred (completed late). For these cases, remediation has already been accomplished. Remediation upon discovery is required only for cases in which an Annual ISP was not completed within 365 days of the prior Annual ISP and was not completed before the AEOM review occurred (completed late).

Table 4.6 Performance Measure SP.a.i.c.2.

Performance Measure: Number and % of waiver participants whose needs changed and whose ISPs were reviewed/ revised accordingly. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants whose needs changed and whose ISPs were reviewed/revised accordingly.*	N	13	22	57
Denominator = *Number of waiver participants reviewed whose needs changed.*	D	25	27	74
	% (N/D)	52%	81%	77%
REMEDIATION DATA				
Noncompliant		12	5	17
AE implemented ODP policies/procedures to address the service need		7	2	11
PUNS not needed		3	1	3
ISP updated		2	1	2
Participant disenrolled		0	1	0
Remediated within 30 days		9	3	14
Remediated within 31-60 days		1	2	0
Remediated within 61-90 days		2	0	1
Remediated in >90 days		0	0	1
# Remediated		12	5	16
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if ISPs were revised when a change in need was identified that required a Waiver service revision. If an ISP is not revised, then the applicable AE and SCO will work together to ensure that correct revisions to the ISP are made. ODP staff persons responsible for AEO record review were trained to identify changes in service need, which resulted in an increased denominator in SY 14/15.

Agency Follow up and Improvement: AEs implemented policies and procedures and retrained staff with a focus on improving documentation of how assessed needs are to be addressed, the content of service notes, PUNS, and ensuring that the loop is being closed. In addition, ODP developed and required two trainings – related to review of content of service notes and documentation for individual monitoring tools to focus on improving continuity within the overall record. In January 2014, ODP conducted a comprehensive review of performance measures and clarified the application of supporting guidelines. ODP staff persons responsible for participant record review were trained to better identify changes in service need, which resulted in an increased denominator in SY 14/15.

CMS Findings and Recommendations:

Based on evidence provided, the State demonstrates that the sub-assurance has been met.

Service Plan Subassurance d - Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Table 4.7 Performance Measure SP.a.i.d.1.

Performance Measure: Number and % of ISPs in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the ISP. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of ISPs in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the ISP.*	N	311	311	299
Denominator = *Number of waiver participants reviewed.*	D	318	314	314
	% (N/D)	98%	99%	95%
REMEDIATION DATA				
Noncompliant		7	3	15
ISP amended to reflect current services needs		2	2	9
HCSIS Monitoring Form reflects current service delivery		1	0	2
Service delivery resolved within 45 days		1	0	1
Service delivery resolved in greater than 45 days		3	0	1
Participant disenrolled		0	1	2
Remediated within 30 days		7	2	8
Remediated within 31-60 days		0	1	3
Remediated within 61-90 days		0	0	3
Remediated in >90 days		0	0	1
# Remediated		7	3	15
% Remediated		100%	100%	100%

Details: Using the sample of Waiver participants drawn through the AEOMP, ODP reviews monitoring conducted by the participant's SC. The ODP standardized individual monitoring tool includes questions evaluating whether services are delivered as specified in the ISP. The tool is completed in HCSIS. In any instance where the Supports Coordinator identifies a concern regarding service delivery, and the issue remains unresolved, the AE will work with the SCO to resolve the situation. Resolution can include but is not limited to changes in service provider, resumption of services at required frequency, team meetings, or changes in service schedule.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates that the sub-assurance has been met.

Service Plan Subassurance e - Participants are afforded choice: between waiver services and institutional care, and between/among waiver services and providers.

Table 4.8 Performance Measure SP.a.i.e.1.

Performance Measure: Number and % of new enrollees who are afforded choice between waiver services and institutional care. (Data Source: HCSIS)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of new enrollees who are afforded choice between waiver services and institutional care (Service Preference Choice or Form 457 Effective Begin Date on or Before Waiver Begin Date).* ***Denominator =*** *All new enrollees.*	N	1,406	1,706	1,556
	D	1,408	1,707	1,558
	% (N/D)	99%	99%	99%
REMEDIATION DATA				
Noncompliant		2	1	2
HCSIS was updated to demonstrate that new enrollees were offered choice between waiver services and institutional care		2	1	2
Remediated within 30 days		2	1	2
# Remediated		2	1	2
% Remediated		100%	100%	100%

Details: On a monthly basis, ODP generates and distributes to the specific AE, HCSIS reports including a list of exceptions for that AE (any individual for whom service delivery preference is not entered into HCSIS as required prior to the Waiver start date). The AE is responsible to review these reports and provide remediation for any situation where Service Delivery Preference has not been completed and/or the date has not been recorded prior to Waiver enrollment. Remediation will include completion of Service Delivery Preference documents and/or data entry into HCSIS. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

Table 4.9 Performance Measure SP.a.i.e.2.

Performance Measure: Number and % of waiver participants whose records document choice between and among services was offered to the participant/family. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants whose records document choice between/among services was offered to the participant/family.*	N	303	307	298
Denominator = *Number of waiver participants reviewed.*	D	311	314	314
	% (N/D)	97%	98%	95%
REMEDIATION DATA				
Noncompliant		8	7	16
Documentation was located		2	3	8
ISP Signature Page, box 3, was completed		4	2	6
SCO retraining		0	2	0
Waiver participant transferred, disenrolled or inactive		2	0	2
Remediated within 30 days		7	6	13
Remediated within 31-60 days		1	1	3
# Remediated		8	7	16
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if participants/ families have been offered choice between and among services and providers. If there was no documentation that choice between and among services was offered, the applicable AE and SCO will work together to locate or complete the documentation on the ISP Signature Page. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

Table 4.10 Performance Measure SP.a.i.e.3.

Performance Measure: Number and % waiver participants whose records document choice between and among providers was offered to the participant/family. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = Number of participants whose records document choice between and among providers was offered to the participant/family.	N	303	307	299
Denominator = Number of waiver participants reviewed.	D	311	314	314
	% (N/D)	97%	98%	95%
REMEDIATION DATA				
Noncompliant		8	7	15
Documentation was located		2	3	9
ISP Signature Page, Box 3 and Box 9, is completed		4	3	5
SCO retraining		0	1	0
Participant inactive or transferred		2	0	1
Remediated within 30 days		5	5	12
Remediated within 31-60 days		1	1	3
Remediated within 61-90 days		1	1	0
Remediated in >90 days		1	0	0
# Remediated		8	7	15
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if participants/ families have been offered choice between and among services and providers. If there was no documentation that choice between and among services and providers was offered, the applicable AE and SCO will work together to locate or complete the documentation on the ISP Signature Page. The ODP standard signature page (DP-1032) is used to document attendance of all participants in ISP meetings. The signature page includes instructions for use and a checklist to ensure the completion of key service planning elements. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

Table 4.11 Performance Measure SP.a.i.e.4.

Performance Measure: Number and % new waiver enrollees and waiver participants who are provided information on participant-directed services. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of new waiver enrollees and waiver participants who are provided information on participant-directed services.*	N	55	304	295
Denominator = *Number of new waiver enrollees and waiver participants.*	D	56	313	313
	% (N/D)	98%	97%	94%
REMEDIATION DATA				
Noncompliant		1	9	18
Documentation was located		1	4	10
ISP signature page was completed		0	1	5
Other		0	4	2
Participant disenrolled		0	0	1
Remediated within 30 days		1	6	13
Remediated within 31-60 days		0	1	4
Remediated within 61-90 days		0	1	0
Remediated in >90 days		0	1	1
Not remediated; referred to appropriate staff for follow-up		0	0	0
# Remediated		1	9	18
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if new Waiver enrollees and Waiver participants (at annual ISP meetings) are provided information on participant directed services. If there is no documentation on the ISP Signature Page that information on participant directed services was provided, the applicable AE will work together with the SCO to review the option with the person, complete and date the portion of the ISP Signature Page regarding participant directed services and indicate on the form that the option of participant directed services was reviewed with the Waiver participant outside of an ISP team meeting.

The SC is responsible to provide the participant and his or her family information on participant-directed services annually. If it is found that this information was not provided, the SC must contact the participant and his or her family to provide them with the necessary information. The ISP Signature Form is used to document that this step was completed along with the date contact occurred. This activity does not require a revision to the participant's ISP unless the participant exercises the right to self-direct services. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days of notification.

During 12/13, ODP updated the ISP signature page (checklist) to include Participant Directed Services (PDS); however the update was not released until October, 2012 and could not be

enforced statewide during this year. Results for SFY 13/14 and forward reflect the inclusion of PDS.

CMS Recommendations:

The State demonstrates the sub-assurance has been met.

III. Qualified Providers Serve Waiver Participants

The state must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. *Authority: 42 CFR 441.302; SMM 4442.4*

The State substantially meets the assurance.

Qualified Providers Subassurance A - The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other State standards prior to their furnishing services.

Table 3.1 Performance Measure QP.a.i.a.1

Performance Measure: Number and percent of new providers that meet required licensure and/or certification standards and adhere to other state standards prior to furnishing waiver services. (Enrollment Unit Spreadsheet)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of new providers that meet required licensure and/or certification standards and adhere to other state standards prior to furnishing waiver services.* ***Denominator =*** *All new providers that require licensure and/or certification.*	N	6	17	42
	D	6	17	42
	% (N/D)	100%	100%	100%

Details: All provider agencies, individual professionals, and vendors that provide services must meet qualification criteria outlined in the Waiver for any new services they intend to provide. AEs are responsible to qualify Waiver providers. To do this, a provider applicant completes an online application and submits required documentation to the qualifying AE. The application and documents are evaluated against objective, standard qualification criteria consistent with the approved Waiver. Providers denied qualification status receive written notice of the decision by the qualifying AE informing them what requirements are not met. Providers may resubmit an application for consideration along with additional documentation that such requirements have been met at any time. Once the provider is qualified, they can continue with the enrollment process where the review of qualifications is also a component of enrollment into PROMISe™.

Table 3.2 Performance Measure QP.a.i.a.2.

Performance Measure: Number and percent of current providers that continue to meet required licensure and/or certification standards and adhere to other state standards. (Data Source: HCSIS)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of current providers that continue to meet required licensure and/or certification standards and adhere to other state standards.*	N	392	182	210
Denominator = *All providers that require licensure and/or certification.*	D	392	182	210
	% (N/D)	100%	100%	100%

Details: Current providers are expected to provide documentation to AEs indicating that they have maintained required licensure and/or certification standards, and adhered to other applicable state standards at the required frequency. Beginning in SFY 13/14 the requalification process was transitioned to a two-year cycle. Therefore, the number of providers reflected annually is reduced. Beginning in SFY 14/15, the Department included revalidation requirements as part of the Medicaid Provider Enrollment and Screening process.

The denominator for this measure in each fiscal year shown is the number of qualified providers with an ODP-issued license (Ch. 2380 Adult Training Facilities, Ch. 2390 Vocational Facilities, Ch. 6400 Adult Residential and Ch. 6500 Family Living Homes) and the number of providers who hold other types of licensure, e.g. a nursing license from the PA Department of State. ODP began conducting provider qualification functions on a two-year cycle in SFY 13-14; 100% of all providers are qualified within any given 2-year cycle. The number of providers reported in SFY 13-14 and SFY 14-15 represent 100% of the 392 providers who held an ODP-issued license (Chapters 2380, 2390, 6400, and/or 6500) and the number of providers who hold other types of licensure, e.g. a nursing license from the PA Department of State, as of June 30, 2015.

CMS Findings and Recommendations:

The State demonstrates the sub-assurance has been met.

Participant Services Subassurance B - The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Table 3.3 Performance Measure QP.a.i.b.1.

Performance Measure: Number and percent of new non-licensed, non-certified providers that meet initial waiver requirements. (Data Source: Enrollment Unit Spreadsheet)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of new non-licensed, non-certified providers that meet initial waiver requirements.*	N	23	35	46
Denominator = *All new non-licensed, non-certified providers.*	D	23	35	46
	% (N/D)	100%	100%	100%

Details: New provider applicants complete an online application and submit required supporting documentation, as identified within the application and also identified in ODP Informational Packet 104-12 to the qualifying AE. New provider qualification applications are reviewed by AEs. Provider applications that do not meet qualification requirements are denied by the AE and are not able to complete the provider enrollment process. Providers who cannot complete the provider enrollment process will receive written notice of the decision, indicating which requirements have not been met. Providers may resubmit an application for consideration along with additional documentation that such requirements have been met.

Table 3.4 Performance Measure QP.a.i.b.2.

Performance Measure: Number and percent non-licensed, non-certified providers that continue to meet waiver requirements. (Data Source: HCSIS)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of current non-licensed, non-certified providers that continue to meet waiver requirements.*	N	261	112	128
Denominator = *All non-licensed, non-certified providers.*	D	257	112	128
	% (N/D)	98%	100%	100%
Provider (SCO) qualified for service		1	0	0
Multiple MPI numbers P/FDS to eliminate duplicate providers		3	0	0
Remediated within 30 days		0	0	0
Remediated within 31-60 days		4	0	0
# Remediated		4	0	0
% Remediated		100%	N/A	N/A

Details: Current providers are expected to provide documentation to AEs indicating that they have maintained required licensure and/or certification standards, and adhered to other applicable state standards at the required frequency. Beginning in SFY 13/14 the requalification process was transitioned to a two-year cycle. Therefore, the number of providers reflected annually is reduced.

ODP conducts provider qualification functions on a two-year cycle; 100% of all providers are qualified within any given 2-year cycle. The number of providers reported in SFY 13-14 and SFY 14-15 represent 100% of the 240 providers who did not hold an ODP-issued license (Chapters 2380, 2390, 6400, and/or 6500) and/or who did not hold other types of licensure, e.g. a nursing license from the PA Department of state, as of June 30, 2015. SCOs are excluded from this measure. Also, there was a typographical error in the numerator and denominator that was previously reported for SFY 12-13; the numerator is 257, and the denominator is 261.

Table 3.5 Performance Measure QP.a.i.b.3.

Performance Measure: Number and percent of providers delivering services to participants who are self-directing that meet initial requirements. (Data Source: ODP Monitoring of Vendor Fiscal Service Provider)		**CY 2012**	**CY 2013**	**CY 2014**
DISCOVERY DATA				
Numerator (N) = *Number of providers delivering services to participants who are self-directing that meet initial requirements.*	N	73	121	356
Denominator = *All providers delivering services to participants who are self-directing.*	D	73	121	356
	% (N/D)	100%	100%	100%

Details: During the course of the state fiscal year new support service worker (SSW) providers apply to be providers to participants who are self-directing services. These SSW providers are required to meet qualification requirements specified in the Waiver. ODP contracts with a vendor fiscal agency to verify qualifications before the SSW provider is enrolled in the participant directed services program.

In 2012, ODP transitioned to a new vendor fiscal agency and increased monitoring of self-directed services. During CY 2013, existing SSW providers who did not meet the end of year qualification requirements were required to enroll as a new provider which is why there was an increase in new SSW providers from CY 2013 and CY 2014.

Table 3.6 Performance Measure QP.a.i.b.4.

Performance Measure: Number and percent of providers delivering services to participants who are self-directing that continue to meet requirements. (Data Source: ODP Monitoring of Vendor Fiscal Service Provider)		**CY 2012**	**CY 2013**	**CY 2014**
DISCOVERY DATA				
Numerator (N) = *Number and percent of providers delivering services to participants who are self-directing that continue to meet requirements.*	N	734	896	962
Denominator = *All current providers delivering services to participants who are self-directing.*	D	734	896	962
	% (N/D)	100%	100%	100%

Details: In 2012 and 2013, the Department received reports from the VF/EA FMS provider (Acumen in 2012, Public Partnerships LLC in 2013 – present) that all SSWs were qualified prior to delivering services. However, when conducting monitoring activities in 2013, the Department discovered that documentation of SSW qualifications by Acumen or PPL was lacking. As a result, the accuracy of the reports submitted by the vendors was in question. This prompted an in-depth review of qualifications and supporting documentation. The Department also enforced a requirement that no SSW could be paid until the qualification documents were obtained and verified by PPL. Upon completion of the in-depth review, all SSWs paid by PPL were found to be qualified and documentation to support qualification had been obtained and retained.

Support Service Workers (SSWs) who deliver Participant-Directed Services are counted in this performance measure. The SSW provider is re-qualified every two years on a calendar year basis because of Tax implications. The last requalification cycle was completed at the end of CY 2014. The number of qualified SSW providers for CY 2015 is 1,042. This number represents 962 plus any new SSW providers qualified since CY 2014. ODP continues to make an effort to expand

Participant Directed Services. The variance in providers noted within this measure represents growth in the number of SSWs who are available to provide services to waiver participants.

CMS Findings and Recommendations:

The State demonstrates the sub-assurance has been met.

Qualified Providers Subassurance C - The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.

Table 3.7 Performance Measure QP.a.i.c.1.

Performance Measure: Number and percent of licensed providers that meet training requirements in accordance with state requirements in the approved waiver. (Data Source: Licensing Database)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of licensed providers that meet training requirements in accordance with state requirements in the approved waiver.*	N	812	269	183
Denominator = *All licensed providers.*	D	854	321	268
	% (N/D)	95%	84%	68%
Licensed providers who did not meet state requirements but complete trainings late and prior to the licensing inspection		N/A	N/A	41
Within 30 days		0	0	8
Within 31 – 60 days		0	0	14
Within 61 – 90 days		0	0	9
In greater than 90 days		0	0	10
Number compliant before remediation		812	269	224
% compliant before remediation		95%	84%	84%
REMEDIATION DATA				
Noncompliant requiring remediation		42	52	44
Located documentation of training		31	27	0
Training provided staff or individual as required		0	0	17
Provider implemented system to ensure training is received timely in the future		11	25	27
Remediated within 30 days		19	39	12
Remediated within 31-60 days		12	10	13
Remediated within 61-90 days		4	3	5
Remediated >90 days		7	0	14
# Remediated		42	52	44
% Remediated		100%	100%	100%

Detail: In July 2012, the Department consolidated all licensing responsibilities under the Bureau of Human Services Licensing (BHSL). As such, oversight of this performance measure is a collaborative effort between BHSL and ODP. BHSL implemented a new enterprise-wide licensing system known as the Certification and Licensing System (CLS) during SFY 13/14. Data in 12/13 and 13/14 reflect a duplicated count of providers if multiple services were provided within a single agency. The identification of providers in CLS is now unduplicated and according to Master Provider Identifier (MPI). As enhancements to the CLS continued, in SFY 14/15 ODP was able to determine instances where licensed providers completed the required training late but prior to the date of the licensing inspection. This information is provided as part of the discovery data.

The Department conducts annual onsite reviews of licensed providers. The Department notes any regulatory violations, including a provider's failure to meet training requirements, and documents the findings on a Licensing Inspection Summary (LIS). The LIS is submitted to the provider who must return the document to the Department within 10 calendar days of the date of transmission from the Department. Providers must specify how the noncompliance has been corrected or will be corrected. The Department will verify that correction has been made through documentation produced by the provider showing evidence that training has occurred and the date it occurred. The provider must correct the identified violation no more than 90 days from the date the LIS was mailed to the provider.

Repeat noncompliance may affect the provider's license status. If the provider is in compliance as determined by the Department at the time a recommendation for licensure is made (i.e., following verification of compliance as described above), a regular license will be issued to the provider. If the provider is not in compliance with applicable regulations as determined by the Department, the Department may issue a provisional license or refuse to issue a license of any kind.

Agency Follow-Up and Improvement: The combination of enhancements to the P/FDS LIS system, updated protocols and procedures, and communication to providers, has improved the integrity of data available to inform this measure. ODP created an Informational Memo informing providers that documentation of remediation is now being reviewed and a provider could be in danger of being sanctioned if the items needed to validate that remediation occurred are not submitted to licensing staff. Sanctions may include issuing a provisional license, non-renewal or revocation of license.

Table 3.8 Performance Measure QP.a.i.c.2.

Performance Measure: Number and percent of non-licensed providers (including SCOs) that meet training requirements in accordance with state requirements in the approved waiver. (Data Source: Provider Monitoring)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of non-licensed providers (including SCOs) that meet training requirements in accordance with state requirements in the approved waiver.*	N	166	136	129
Denominator = *All non-licensed providers (including SCOs).*	D	215	162	163
	% (N/D)	77%	84%	79%
REMEDIATION DATA				
Noncompliant		39	26	34
Staff Trained		34	22	30
Documentation developed/Missing documentation located		1	3	0
Provider voluntarily discontinued services		1	1	3
Provider services "not qualified"		1	0	0
Provider/Staff terminated		2	1	0
Remediated within 30 days		26	20	21
Remediated within 31-60 days		9	4	10
Remediated within 61-90 days		1	0	3
Remediated >90 days		3	2	0
# Remediated		39	26	28
% Remediated		100%	100%	100%

Details: Through the provider monitoring process, on a two-year cycle, AEs conduct on-site reviews of 100% of providers using the standardized monitoring tools developed by ODP. AEs review training records of the last 10 direct support staff members who were hired by each provider during the prior fiscal year.

Within the provider monitoring process, all providers are monitored within a two-year period which makes up one cycle. Since all providers are monitored and this specific measure is related to non-licensed providers, ODP conducts an analysis to identify the "non-licensed" providers. For this analysis, the definition of "non-licensed" providers are providers who do not hold an ODP license (i.e. Ch. 2380 Adult Training Facilities, Ch. 2390 Vocational Facilities, Ch. 6400 Adult Residential and Ch. 6500 Family Living Homes); other licensed services such as registered nurses (RNs) are included in the denominator. The reason for "non-licensed" providers being defined in this way is to ensure that all providers are included in the data. Since the information from measure QPa.i.c.1 comes from licensing for ODP licensed providers (Bureau of Human Services Licensing, BHSL), the remainder of the providers including Supports Coordination Organizations (SCOs) are captured in this measure. If a provider offers both licensed and non-licensed services, that provider is not included in the denominator for this measure.

Through the supports coordination organization (SCO) annual monitoring process, ODP conducts on-site reviews of 100% of the SCOs using the standardized monitoring tools developed by ODP. ODP reviews the training records for all SCs and SC supervisors with a waiver caseload to determine that they attended and completed all required trainings.

If the required staff training is not documented in the record, ODP or the applicable AE will notify the provider and the provider must locate missing documentation or ensure that training is provided within 30 days. The remediation for this process will occur as outlined in the ODP-established corrective action process.

Agency Follow up and Improvement: The implementation of a Provider Applicant orientation training which will begin in January 2016 includes a component to reinforce ODP expectations for SSWs to understand each participants ISP and support them in achieving their goals.

ODP continues with a close oversight and review of non-licensed providers to ensure adequate staff training exists at the provider level and that this training is received and completed by all newly hired staff members. This allows ODP to continue with a systematic plan for improvement. To date, efforts have focused on development and standardization of monitoring tools and enhancement of data collection and gathering to produce reports. ODP has developed a standardized termination/sanction process that is now being used as a result of previous recommendations for improvement.

ODP has communicated this standardized process via Informational Memo #062-15, issued July 31, 2015. “Enforcement Actions against Noncompliant ODP Intellectual Disability Waiver Providers” details sanctions that may be taken based on ODP's authority in the 55 Pa. Code Chapter 51 regulations. ODP has also established a sanction policy to articulate actions that may be taken in the event of repeat non-compliance. These sanctions include withholding, disallowing, suspending or recouping payment or future payment, disallowance of new service locations, services or newly-enrolled individuals.

A detailed review of monitoring results from this current provider monitoring cycle will be completed to inform additional areas that need improvement, collaboration with AEs, and training.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates the sub-assurance has been met.

IV. Health and Welfare of Waiver Participants

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.
Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

The State substantially meets the assurance.

Assurance: The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.

ODP uses a comprehensive electronic, internet-based reporting solution for incident management known as the Home and Community Services Information System (HCSIS). All provider entities use HCSIS to report incidents to ODP and the AEs. The ODP incident management lifecycle contains an initial notification process (known as the first section submission), investigation if warranted, final notification process (known as the final section submission), and approval process (known as the closure of the incident) as outlined in Incident Management Bulletin 6000-04-01.

When an event occurs, or is alleged to have occurred, that is considered an incident per policy, the reporting entity must submit the first section of the incident report to ODP and the AE within 24 hours of discovery or recognition. This first section of the incident report includes a description of the event, incident categorization, as well as the action taken to ensure the health and safety of the individual. Once the initial notification is submitted, ODP and the AE will review the incident first section to ensure that prompt action was taken to protect the participant's health, safety, and rights.

Certain categories of incidents are considered *critical incidents*. Critical incidents are incidents that require an investigation to be completed by an ODP certified investigator. Critical incidents are events of abuse, neglect, misuse of funds, rights violations and death. Misuse of funds and rights violations are considered exploitation. As part of the investigation, an investigator must take the first witness statement within 24 hours of being assigned an investigation. The investigator must also complete all witness interviews within 10 days of being assigned the investigation. The investigation and a final investigation determination (either confirmed or not confirmed) must be completed within 30 days. These are the ODP investigation standards (measured as part of H&W a.i.4).

An incident report is considered *finalized* when the reporting entity submits the Final Section of the incident report to ODP and the AE. Where appropriate, the final section of the incident will include the investigation determination as well as the corrective actions that were carried out or planned in order to mitigate and prevent the reoccurrence of the incident.

All incident reports must be finalized within 30 days from the date of discovery or recognition or the incident report is not considered timely. If the reporting entity cannot finalize the incident report within 30 days due to circumstances beyond their control, the provider entity can input an extension notification. When the need for extension is submitted, the reporting entity is obligated to adhere to the extension deadline otherwise the finalization of the incident report is not considered timely.

When the reporting entity finalizes an incident report, ODP and the AE perform a review of the incident report within 30 days from the date of finalization. ODP and the AE review and make a determination regarding the investigation, corrective actions, and other pertinent information to ensure that the incident was managed effectively.

Table 5.1 Performance Measure HW.a.i.1.

Performance Measure: Number and percent of critical incidents in which prompt action (demonstrated within 24 hours) is taken to protect the participant's health, safety and rights. (Data Source: Incident Management Log) Data Pull September, 2015		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of critical incidents in which prompt action is taken to protect the participant's health, safety and rights.*	N	491	650	625
Denominator = *Number of critical incidents.*	D	491	650	625
	% (N/D)	100%	100%	100%

Details: Both ODP and AEs review critical incidents within 24 hours of entrance into HCSIS. In any incident reviewed by ODP staff when it is not clear that adequate or prompt action has been taken to protect the participant's health, safety and rights, ODP will notify the AE that day (or the next business day if the incident was reviewed during non-work hours) to ensure that appropriate action relevant to the incident type has been taken. The AE will work with the provider to ensure that action has been undertaken to protect the participant's health, safety and rights and submit notification to ODP documenting what remediation actions occurred within 24 hours. The numerator for HWa.i.1 includes a review of all incidents (as opposed to solely critical incidents) as all incident report first section submissions must outline the prompt action taken by the reporting entity to protect the health, safety, and rights of the individual.

As part of the first section review completed by ODP and AE, if it is discovered that prompt action was not taken by the reporting entity to protect the health, safety, and rights of the individual, ODP and/or the AE will communicate with the reporting entity and direct action so that remediation occurs within 24 hours of discovery by ODP or the AE. This process ensures the health and safety of the individuals served, while performing administrative authority duties specific to the management of incidents.

The numbers provided above reflect all alleged critical incidents. In SFY 13-14, the Department of Human Services implemented the Adult Protective Services program and trained to the mandatory reporting requirements outlined in the Act. Due to this training, ODP saw an increase in allegations being reported. The remediation strategies can include but are not limited to the following:

- assessment of injury
- first aid or CPR administered
- primary care physician, emergency room or hospital visit
- notification to law enforcement
- crime victim services
- contact local domestic violence providers
- contact local rape crisis center
- formal and informal counseling
- respite services.

Table 5.2 Performance Measure HW.a.i.2.

Performance Measure: Number and percent of AEs that review incidents within 24 hours of the report. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of AEs who review incidents within 24 hours of the report.* ***Denominator =*** *Number of AEs.*	N	18	19	14
	D	18	19	14
	% (N/D)	100%	100%	100%

Details: Through the AEOMP, ODP evaluates incidents filed for participants in the sample to ensure timely review by the AE. ODP documents the timeframe within which remediation action has occurred or will be completed by the AE. ODP requires the AE to develop a Corrective Action Plan to prevent future occurrences. A single instance of non-compliance results in a noncompliance for the AE. While 100% of AEs are reviewed for this measure, not all AEs have incidents identified for review within the sample. The total number of AEs is 48. While 100% of AEs are reviewed for this measure, not all AEs have incidents identified for review within the sample.

Table 5.3 Performance Measure HW.a.i.3.

Performance Measure: Number and percent of critical incidents finalized within the required time frame (30 days). (Data Source: HCSIS)		**SFY 12-13** As of August 2013	**SFY 13-14** As of August 2014	**SFY 14-15** As of Sept. 2015
DISCOVERY DATA				
Numerator (N) = *Number of critical incidents critical incidents finalized within the required time frame.* ***Denominator = All*** *critical incidents, by type.*	N	230	318	441
	D	381	572	595
	% (N/D)	60%	56%	74%
REMEDIATION DATA				
Noncompliant		151	254	154
Provider finalized critical incident in HCSIS		151	254	154
Remediated within 30 days		77	161	113
Remediated within 31-60 days		41	40	30
Remediated within 61-90 days		14	23	9
Remediated in >90 days		19	30	2
# Remediated		151	254	154
% Remediated		100%	100%	100%

Details: ODP staff monitors a monthly report of critical incidents that are not finalized within 30 days and have no extension filed. This information is provided to AEs who contact providers to determine why incidents have not been finalized and why extensions have not been filed. If a

provider does not finalize a critical incident within the required timeframe, the provider must finalize the incident within 5 days or file an extension request, if there are circumstances which support the need for an extension.

This measure is a subset of incidents identified in HW.a.i.1 and focuses on all critical incidents that have been finalized as of the date of the data extraction.

Agency Follow up and Improvement: Actions taken over time have contributed to improvement in SFY 14/15 and that improvement is expected to continue moving forward. ODP will continue to expect AEs to monitor provider performance in finalizing critical incidents using a management level report that provides 100% review of all incident submission deadlines. This report supplements the Incident Management Process Status reports used daily. A monthly "aging incidents" report will continue to be reviewed at regional risk management meetings with AEs for providers within their scope of oversight authority.

As part of the improvement strategy, ODP added questions to the provider monitoring tool and process that assess the provider's performance regarding compliance with the timely finalization of incident reports. Providers that have a low compliance percentage are now issued a corrective action plan and asked to develop an internal policy and procedure to increase their compliance.

Informational Memo #025-15 regarding the importance of timely finalization of incidents was issued 3/27/15 to reinforce the requirements for finalizing an incident report within a 30 day timeframe or filing an extension if the 30 day timeframe cannot be met.

During SFY 14/15, ODP has worked to transition from HCSIS to an Enterprise Incident Management (EIM) system which presents an opportunity for more complete documentation of incidents and timeframes for resolution. The transition is planned for January 2016. In EIM, a dashboard report will serve as a mechanism for incident point persons and certified investigators to more easily manage tasks, in an effort to ensure timely finalization of incidents. The dashboard will provide a summary of the user's workload, and allow the user to view and manage tasks from one screen. A summary of the incidents in need of a user's attention will be among the first items displayed when a user logs-on to the system. Incidents will be grouped by submission and finalization timeframes so that users will know the items require their immediate attention. AE incident reviewers will have a dashboard that details the specific incidents in need of finalization. This tool will help AEs conduct oversight authority activities and assist them with determining which providers may be in need of technical assistance in order to comply with this requirement.

Table 5.4 Performance Measure HW.a.i.4.

Performance Measure: Number and percent of AEs that completed investigations in accordance with ODP standards. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of AEs that completed investigations in accordance with ODP standards.*	N	18	17	30
Denominator = *Number of AEs reviewed.*	D	40	42	45
	% (N/D)	45%	41%	67%
REMEDIATION DATA				
Noncompliant		22	25	15
Certified Investigator is counseled as appropriate to ODP standards		16	18	11
Certified Investigator is retrained as appropriate to ODP standards		6	7	1
Monitoring protocol submitted and accepted		0	0	1
AE staff directed to use ALERT system in HCSIS		0	0	1
Electronic tickler developed by AE		0	0	1
Remediated within 30 days		21	20	12
Remediated within 31-60 days		1	2	3
Remediated within 61-90 days		0	3	0
Remediated in >90 days		0	1	0
# Remediated		22	25	15
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of investigations completed by AEs to determine if ODP investigation standards were met. If ODP expectations were not met, AEs will initiate remediation which may include counseling and/or retraining of certified investigators. Documentation of remediation actions must be submitted to ODP within 30 days. As part of the investigation, an investigator must take their first witness statement within 24 hours of being assigned an investigation. The investigator must also complete all witness interviews within 10 days of being assigned the investigation. The investigation and a final investigation determination (either confirmed or not confirmed) must be completed within 30-days.

Agency Follow up and Improvement: During SFY 14/15, ODP clarified the application of guidelines for review of this measure. Through analysis, ODP recognizes the need to establish criteria to allow for extenuating circumstances and/or offer opportunity for exception to timeframes in cases such as states of emergency, circumstances beyond the control of the investigator.

Table 5.5 Performance Measure HW.a.i.5.

Performance Measure: Number and percent of critical incidents, confirmed, by type. (Data Source: HCSIS) **Numerator (N):** Number of Incidents of Abuse, Neglect, Rights Violations, Misuse of Funds, or Death in Provider Operated Setting, respectively		**SFY S 12-13**	**SFY 13-14**	**FY 4-15 1**
DISCOVERY DATA				
	Total Number of Critical Incidents, Confirmed **(D)**	195	319	304
Abuse	(N/D) %	122/195 62.5%	162/319 50.7%	152/304 50%
Neglect	(N/D) %	58/195 29.7%	125/319 39.1%	123/304 40.4%
Rights Violation (exploitation)	(N/D) %	6/195 3%	18/319 5.6%	11/304 5.9%
Misuse of Funds (exploitation)	(N/D) %	9/195 4.6%	14/319 4.3%	18/304 3.6%

Details: This performance measure is designed to support evaluation of trends and patterns in the occurrence of critical incidents. The number and percent of critical incidents, confirmed, by type is reviewed to identify opportunities for systemic improvement as described in Appendix H. This measure is a subset of HWai3 and focuses only on confirmed critical incidents (incidents of abuse, neglect, exploitation and death).The denominator reported for this measure represents the total number of critical incidents, confirmed, by type, per state fiscal year.

In addition to the Child Protective Services Law and the Older Adult Protective Services Act, the implementation of the Adult Protective Services Act in July 2014 has established mandatory reporting requirements for Community members (doctors, nurse, EMTs, teachers, bus drivers, etc.) to report suspected abuse, neglect (including abandonment) and exploitation of individuals between the ages of 18 to 59 with an intellectual disability that they see in the community. Since that time, neglect allegations have increased; however, the percent of critical incidents that are confirmed remains consistent with prior years.

Agency Follow up and Improvement: The number and percent of critical incidents confirmed, by type are reviewed to identify opportunities for systemic improvement. ODP continues to encourage reporting of critical incidents. With each critical incident confirmed a corrective action is carried out or planned by the appropriate entity. ODP continues to develop incident management and risk mitigation trainings for all stakeholders and provide targeted technical assistance as needed.

Enhancements were made to the ODP Certified Investigation course. Specifically, the state strengthened the training content related to conducting a preponderance of evidence standard and clarified the definitions of "confirmed, not confirmed, and inconclusive". In addition, the state continues to enhance the course with best practices. ODP provided education about recognition and reporting to all AEs, supports coordination organizations and providers. In conjunction with the Division of Adult Protective Services, mandatory reporting training was developed and issued to all AEs, supports coordination organizations and providers.

ODP developed and released a series of trainings specific to "Identifying and Mitigating Risk". These trainings are available to all stakeholders including AEs, supports coordination organizations, provider agency staff, and individual and families. These trainings focus on

practices to help teams assess potential risks, develop risk mitigation strategies, implement mitigation strategies, evaluate strategies for effectiveness and success, recognize progress and assess again, and identify if additional strategies are warranted.

Table 5.6 Performance Measure HW.a.i.6.

Performance Measure: Number and percent of critical incidents, confirmed, where corrective actions were carried out or planned by the appropriate entity within the required time frame. (Data Source: HCSIS)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of critical incidents, confirmed, where corrective actions were carried out by the appropriate entity within the required timeframe.*	N	164	262	130
Denominator = *Number of critical incidents, confirmed, where corrective actions were required.*	D	164	262	131
	% (N/D)	100%	100%	99%
REMEDIATION DATA				
Noncompliant		0	0	1
Clarifying Detail Regarding Corrective Action(s) Added to Report		0	0	1
Remediated within 30 days		0	0	1
# Remediated		0	0	1
% Remediated		N/A	N/A	100%

Details: The AE and ODP review confirmed critical incidents to ensure that corrective actions resulting from certified investigation are carried out or planned by the appropriate entity within the required timeframe. If corrective actions are not carried out or planned by the appropriate entity within the required time frame, the AE or ODP will follow up to ensure the corrective actions are carried out or planned within 10 days. All remediation steps are entered into the incident report and are subject to final approval by ODP.

Table 5.7 Performance Measure HW.a.i.7.

Performance Measure: Number and percent of waiver participants who received information about reporting abuse, neglect, and exploitation. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants who received information about reporting abuse, neglect, and exploitation.*	N	7	276	295
Denominator = *Number of waiver participants in the sample.*	D	7	311	314
	% (N/D)	100%	89%	94%
REMEDIATION DATA				
Noncompliant		0	35	19
Documentation was located		0	7	10
ISP Signature Page was completed		0	13	8
SC Training		0	15	1
Remediated within 30 days		0	4	4
Remediated within 31-60 days		0	21	12
Remediated within 61-90 days		0	10	2
# Remediated		N/A	35	19
% Remediated		N/A	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if participants/ families have been provided information about reporting abuse, neglect and exploitation. If there was no documentation that the information was provided, the AE will work with the SCO to provide the information to the participant/family and complete the required documentation on the ISP Signature Page. In some cases where the information was provided but not documented, the ISP Signature Page is updated. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days.

During SFY 12/13, ODP updated the ISP signature page (checklist) to include a question to validate the individual was provided information about reporting abuse, neglect and exploitation. Use of the ISP signature page was initiated during SFY 12/13 but not fully implemented that year, explaining the increase in reporting from SFY 12/13 to SFY 13/14 and forward.

Table 5.8 Performance Measure HW.a.i.8.

Performance Measure: Number and percent of AEs that maintain documentation of incident management training. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of AEs that maintain documentation of incident management training.*	N	44	47	44
Denominator = *Number of AEs.*	D	48	48	48
	% (N/D)	92%	98%	92%
REMEDIATION DATA				
Number noncompliant		4	1	4
Documentation is located verifying that IM training has been done		1	0	0
Documentation that training has been completed is provided		3	1	4
Remediated within 30 days		4	0	4
Remediated within 31-60 days		0	0	0
Remediated within 61-90 days		0	1	0
Remediated in >90 days		0	0	0
Not remediated; referred to appropriate staff for follow-up		0	0	0
# Remediated		4	1	4
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews AEs to determine if incident management training has occurred. When documentation of Incident Management training cannot be produced, AEs must complete the training and/or provide documentation that training has occurred and implement a Corrective Action Plan to prevent future noncompliance. AEs are expected to document the remediation actions and submit the documentation to ODP within 30 days.

Table 5.9 Performance Measure HW.a.i.9.

Performance Measure: Number and percent waiver participants for whom there was an unreported critical incident, by type. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants for whom there was an unreported critical incidents, by type of incident.*	N	5	5	4
Denominator = *Number of waiver participants in the sample.*	D	311	314	314
	% (N/D)	1.61%	1.59%	1.27%
REMEDIATION DATA				
Noncompliant		8	9	4
Number of critical incidents of abuse that were not reported		4	1	2
Number of critical incidents of neglect that were not reported		3	7	2
Number of critical incidents of exploitation that were not reported		1	0	0
Number of other critical incidents that were not reported		0	1	0
Unreported critical incidents filed in HCSIS within 24 hours of notification		0	2	0
# Remediated		8	9	4
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of participant records to ensure that critical incidents are reported. If it is determined that a critical incident was not reported, ODP will notify the AE immediately. The AE will instruct the provider to enter the information into HCSIS, work with the provider to ensure that action has been undertaken to protect the participant's health, safety and rights and will submit notification to ODP documenting what remediation actions occurred within 24 hours.

The number of unreported incidents is greater than the number of participants with unreported incidents which aligns with the measure; however, in order to ensure the health and safety of all participants, remediation serves to ensure that all identified unreported incidents are filed.

ODP follows the standard incident management process when the unreported critical incident is discovered. This includes follow-up with the participant/family regarding notification of the incident, the outcome of the investigation, and the implementation of all necessary corrective actions. ODP validates remediation through the AEOMP Corrective Action Plan (CAP) process. Remediation strategies include:

- the unreported critical incident is filed in HCSIS within 24 hours
- the unreported critical incident is remediated through the incident management process
- the unreported critical incident is referred to appropriate staff for follow-up.

Table 5.10 Performance Measure HW.a.i.10.

Performance Measure: Number and percent of deaths, by cause of death. (Data Source: Mortality Review Database)		**CY 2012**	**CY 2013**	**CY 2014**
DISCOVERY DATA				
Numerator (N)= *Number of deaths, by cause of death.* ***Denominator (D) =*** *All deaths.* ***% = (N)/(D)***	Total Deaths **(D)**	63	46	46
BY TYPE				

	2012 ***(N)/(D) %***		**2013** ***(N)/(D) %***		**2014** ***(N)/(D) %***
Cancer	14/63 22%	Cancer	6/46 13%	Diseases of Heart	12/46 12%
Heart Disease	12/63 19%	Diseases of Heart	10/46 22%	Cancer	6/46 13%
Congenital	8/63 13%	Unknown	6/46 13%	Unknown	5/46 11%
Dementia, Alzheimer	6/63 9.5%	Indeterminate	1/46 2%	ACCIDENTAL	2/46 4.3%
Operative/Post-operative Complications	5/63 8%	Diseases of the nervous System	2/46 4%	Asphyxiation	1/46 2.2%
Seizure	4/63 6%	Asphyxiation	1/46 2%	Cerebrovascular accident	1/46 2.2%
Asphyxia (choking and fire deaths)	3/63 5%	Disease of the Respiratory system	1/46 2%	Inanition (Adult Failure To Thrive)	1/46 2.2%
Unknown	2/63 3%	Pneumonia	1/46 2%	Diseases of the nervous System	1/46 2.2%
Diseases of the digestive system	2/63 3%	Blank	18/46 39%	Pneumonia	1/46 2.2%
Pneumonia	1/63 1.6%			Seizure Disorder	1/46 2.2%
Fall	1/63 1.6%			Sepsis	1/46 2.2%
Disease of the vessels (stroke)	1/63 1.6%			Surgical Complications	1/46 2.2%
Chronic kidney disease	1/63 1.6%			Blank	13/46 28%
Shunt malfunction	1/63 1.6%				
Diabetes	1/63 1.6%				
Inanition	1/63 1.6%				

Details: This performance measure is designed to support evaluation of trends and patterns in the occurrence of deaths. The number and percent of deaths is reviewed to identify opportunities for systemic improvement. The denominator reported for this measure represents the total number of deaths per calendar year.

The causes of death are presented in order to examine findings within the context of CDC National Center for Health Statistics (NCHS) for both the US and PA. The top causes of death are fairly stable across the last three years in terms of numbers and percentage of cause of death – diseases of the heart and cancer. Diseases of the heart include additional cases where cause of death (COD) on death certificate was *Cardiac Arrest* and where no additional information was available to further clarify the COD. The incidence of most other causes of death is too small to analyze. Diseases of the heart include cases where COD on death certificate was *Cardiac Arrest* and where no additional information was available to further clarify the COD.

ODP, consistent with general public health practices, utilizes findings to plan health related remediation, health prevention/management and health education/promotion activities designed to help people to live longer and healthier lives as well as improve quality of life overall. However, before such activities can be designed and implemented, data integrity and validity need to be improved.

ODP experienced challenges during this Waiver cycle in designating causes of death as death certificates are not always available; and information in the death certificate is not always reliable. Additionally, the mortality review process is time consuming and manual. Further, because some of the COD counts are small, it is difficult to determine to what extent this information is reflective of the causes of death for the PA I/DD population in general.

Agency Follow up and Improvement: ODP will examine the mortality review process and identify strategies to streamline review that include best practices and are standardized, user-friendly, and support reliable and valid analysis as well as prevention and promotion efforts. ODP will communicate with appropriate medical authorities to provide outreach education regarding the need to correctly complete death certificates by following the CDC Instructions for Completing the Cause-of-Death Section of the Death Certificate (CDC publication) and the PA DOH Bureau of Health Statistics Research 2012 Death Certificate Registration Manual.

Table 5.11 Performance Measure HW.a.i.11.

Performance Measure: Number and percent of deaths of waiver participants examined according to State protocols. (Data Source: Mortality Review Database)		**CY 12-13**	**CY 13-14**	**CY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of deaths of waiver participants examined according to State protocols.*	N	0	0	0
Denominator = *Number of deaths of waiver participants requiring examination according to State protocols.*	D	0	0	0
	% (N/D)	N/A	N/A	N/A

Details: The measure "number of deaths of Waiver participants examined according to State protocols" applies only to those living in licensed residential settings and does not apply to the P/FDS Waiver since consumers must live either in their own home or a relative's home.

Table 5.12 Performance Measure HW.a.i.12.

Performance Measure: Number and percent of incidents of restraint where proper procedures were followed, by type of restraint. (Data Source: HCSIS)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of incidents of restraint where proper procedures were followed, by type of restraint.*	N	39	18	14
Denominator = *Number of incidents of restraint, by type of restraint.*	D	39	18	14
	% (N/D)	100%	100%	100%

Details: ODP regulations specify that any Waiver participant who has two emergency restraints within a six month period must have a behavior support plan with a restrictive procedure plan. When ODP discovers that proper procedures were not followed, a behavior support plan with a restrictive procedure plan that meets ODP regulations must be developed, approved and implemented within 30 days.

ODP regional risk managers monitor the type of restraint to ensure that whenever possible, restraints are part of an approved behavior support plan. 93% of all reported restraints were part of an approved plan. Of the emergency restraints which occurred, 99% were physical restraints in 99% of restraints administered. Through the dual diagnosis initiative leads, ODP focuses technical support on assisting providers to apply restraint reduction techniques for participants who experience multiple restraints to better manage risks associated with restrictive interventions.

Table 5.13 Performance Measure HW.a.i.13.

Performance Measure: Number and percent of medication errors, by type. (Data Source: HCSIS)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of medication errors, by type.* ***Denominator =*** *All medication errors.* ***%=(N)/(D)***	Total Medication Errors **(D)**	61	67	85
BY TYPE				
Omission	(N/D) %	41/61 67.2%	53/67 79.1%	56/85 65.9%
Wrong Dose	(N/D) %	12/61 19.7%	6/67 9.0%	14/85 16.5%
Wrong Medication – extra dose	(N/D) %	1/61 1.6%	3/67 4.5%	3/85 3.5%
Wrong Person	(N/D) %	1/61 1.6%	1/67 1.5%	1/85 1.2%
Wrong Technique or Method	(N/D) %	1/61 1.6%		
Wrong Time	(N/D) %	5/61 8.2%	4/67 6.0%	11/85 12.9%

Details: This performance measure is designed to support evaluation of trends and patterns in the occurrence of medication errors. The number and percent of medication errors is reviewed to identify opportunities for systemic improvement. The denominator reported for this measure represents the total number of medication errors per state fiscal year. Most consumers served by the P/FDS Waiver reside at home. Medication errors that may occur under these circumstances are not reportable. A medication error is reported for a P/FDS consumer when that person is participating in a service from a provider and a medication is due for administration while with that provider/staff. Consequently, the numbers continue to be low. The types of errors most frequently reported are omission, wrong dose and wrong time, in that order.

Analysis of the remediation data reveals that there were no errors that could not be evaluated related to remediation. The average number of remediation activities per medication error for this fiscal year was 1.9 with the most common continuing to be *contacted program supervisor, contacted healthcare professional, observed for side effects,* and *no action needed*. No medication errors resulted in a visit to the emergency department or hospital. There were an additional 128 actions taken by the provider agency to prevent medication error recurrence. The most frequently cited actions in rank order were: 1) individual feedback to employee; 2) Training/Retraining. The average number of actions taken to remediate and prevent recurrence was 3.4 actions per error. There were a total of 286 actions taken during this fiscal year which is reflective of the new information integrated into the new medication administration course materials which were implemented Fall 2013.

The increases noted in both the count of medication errors and remediation and prevention activities are attributed to the addition of new information about medication administration best practices integrated into the medication administration training. Awareness of what constitutes a medication error and the recognition of a medication error result in better reporting. It is not unusual to see increases in the count of medication errors or better reporting following training events.

Agency Follow up and Improvement: ODP will continue to monitor patterns and trends in analysis of types of medication errors, cause, remediation and preventive actions to identify improvement opportunities. ODP will evaluate new information about medication administration best practices to incorporate into both the initial course and on-going medication administration monitoring. ODP will evaluate new information about medication errors to determine causes and contributing factors to develop additional remediation and teaching strategies and continue to update all trainers with findings and recent developments in medication administration best practices.

Table 5.14 Performance Measure HW.a.i.14.

Performance Measure: Number and percent of complaints, by type. (Data Source: Compliant Log)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of complaints, by type.* ***Denominator (D) =*** *All complaints.* ***%=(N)/(D)***	Total Number of Complaints **(D)**	39	32	31
BY TYPE*				
Abuse of Individual	(N/D) %	2/39 5%	5/32 16%	2/31 6%
Administrative Entity	(N/D) %	4/39 10%	4/32 13%	6/31 19%
Direct Support Staff	(N/D) %	6/39 15%	1/32 3%	0/31 0%
Exploitation of Individual	(N/D) %	1/39 3%	0/32 0%	1/31 3%
HCBS Waiver	(N/D) %	1/39 3%	2/32 6%	1/31 3%
Neglect of Individual	(N/D) %	1/39 3%	2/32 6%	1/31 3%
Office of Developmental Programs	(N/D) %	0/39 0%	1/32 3%	1/31 3%
Other	(N/D) %	12/39 31%	5/32 16%	5/31 16%
Provider Agency	(N/D) %	11/39 28%	6/32 19%	7/31 23%
Supports Coordination Organization	(N/D) %	1/39 3%	6/32 19%	7/31 23%

Details: For purpose of this measure, the Department applies the CMS technical guide definition of "complaint," which is "the formal expression of dissatisfaction by a participant with the provision of a Waiver service or the performance of an entity in conducting other activities associated with the operation of a Waiver." Complaints may be received from program participants, family members and representatives, AEs, providers, advocates, and other interested parties through a centralized customer service line. This performance measure is designed to support evaluation of trends and patterns in the occurrence of complaints. The number and percent of complaints is reviewed to identify opportunities for systemic improvement. The denominator reported for this measure represents the total number of complaints per fiscal year. The complaint types shown reflect the type of allegation or the entity against which the complaint is directed.

Table 5.15 Performance Measure HW.a.i.15.

Performance Measure: Number and percent of complaints resolved within 21 days of receipt. (Data Source: Compliant Log)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of complaints resolved within 21 days of receipt.* ***Denominator =*** *Number of complaints received.*	N	26	21	26
	D	39	32	31
	% (N/D)	67%	66%	84%
REMEDIATION DATA				
Number noncompliant		13	11	5
Remediated within 31-60 days		0	0	3
Remediated in > 90 days		1	0	2
Resolution date not recorded		12	11	0
# Remediated		13	11	5
% Remediated		100%	100%	100%

Details: All complaints were resolved; however, resolution dates were not captured in the log for FY 12-13 and portions of FY 13-14. This identified problem was corrected in FY 14-15.

Agency Follow up and Improvement: The Department is reviewing its complaint intake and response documentation procedures to improve reliability and consistency in measurement in SFY 15-16. Planned objectives include updating the procedures and tools used in the administration of the customer service line. Some complaints could only be resolved via the Department's investigative procedures, which allow for investigation timeframes longer than 21 days. Allowances for extensions in complex cases, and adherence to documentation standards are slated to be addressed in the Department's revised complaint procedures.

Table 5.16 Performance Measure HW.a.i.16.

Performance Measure: Number and percent of providers that ensure waiver participants receive physical exams in accordance with ODP rules. (Data Source: Licensing Data)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of providers that ensure waiver participants receive physical exams in accordance with ODP rules.*	N	812	217	226
Denominator = *Number of providers reviewed.*	D	854	269	259
	% (N/D)	95%	81%	87.26%
Number of physical exams completed late		N/A	N/A	22
Within 30 days		N/A	N/A	10
Within 31 – 60 days		N/A	N/A	4
Within 61 – 90 days		N/A	N/A	5
In greater than 90 days		N/A	N/A	3
Number compliant before remediation		N/A	N/A	237
% compliant before remediation		N/A	N/A	88%
REMEDIATION DATA				
Noncompliant		42	30	0
Missing physical exam located		31	10	0
Not remediated; refer to appropriate staff for follow-up		11	20	0
Remediated within 30 days		18	13	0
Remediated within 31-60 days		13	9	0
Remediated within 61-90 days		4	3	0
Remediated in >90 days		7	5	0
# Remediated		42	30	0
% Remediated		100%	100%	N/A

Details: In July 2012, the Department consolidated all licensing responsibilities under the Bureau of Human Services Licensing (BHSL). As such, oversight of this performance measure is a collaborative effort between BHSL and ODP. BHSL implemented a new enterprise-wide licensing system known as the Certification and Licensing System (CLS) during SFY 13/14. Data in 12/13 and 13/14 reflect a duplicated count of providers if multiple services were provided within a single agency. The identification of providers in CLS is now unduplicated and according to Master Provider Identifier (MPI).

The Department conducts annual onsite reviews of licensed providers. The Department notes any regulatory violations, including a provider's failure to meet the requirement for Waiver participants to receive annual physical examinations, and documents the findings on a Licensing Inspection Summary (LIS). The LIS is submitted to the provider who must return the document to the Department within 10 calendar days of the date of transmission from the Department. Providers must specify how the noncompliance has been corrected or will be corrected.

The Department will verify that correction has been made through documentation produced by the provider showing evidence that the physical exam occurred and the date it occurred. The provider must correct the identified violation no more than 90 days from the date the LIS was mailed to the provider.

Upon receipt of a complaint, regional office staff contacts the complainant to acknowledge receipt of the complaint and to collect additional information, unless the complainant is anonymous or did not provide contact information. Once comprehensive intake information is received, regional office staff determines whether the complaint should be investigated by ODP or an entity subject to ODP's direct authority (i.e. an administrative entity, supports coordination organization, or provider), or if the complaint should be referred to an external oversight entity, e.g. the Bureau of Human Services Licensing, the Pennsylvania Department of Health, Pennsylvania Adult Protective Services, law enforcement, etc.

In cases where the complaint is investigated by ODP or its subordinate entities, regional office staff provides direction and information to the investigating entity and recommend they follow up with the reporting participant/family. In some cases, depending on the nature of the complaint, the regional office staff follows up with the person reporting to provide the investigation results and/or ensure resolution fully addressed the concerns. In cases where the complaint is referred to an external oversight entity, ODP notifies the complainant that the referral has been made, and that the external entity will notify the complainant of the investigation results in accordance with the entity's policy on follow-up to complainants. Additionally, complainants can and do contact the ODP Customer Service Line to inquire about the status of an investigation. Calls of this type are referred to the investigating region for appropriate response.

V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Authority: 42 C'FR 441.303; 42 CFR 431• SMM 4442.6; SMM 4442.7

The State substantially meets the assurance.

Assurance: The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Table 1.1 Performance Measure AA.a.i.1.

Performance Measure: Number and percent of AEs that implement monitoring protocols using the ODP standardized monitoring tool. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
***Numerator (N)** = Number of AEs that implement monitoring protocols using the ODP standardized monitoring tool. **Denominator (D)** = Number of AEs that delegate or purchase administrative functions.*	N	19	21	27
	D	24	29	31
	% (N/D)	79%	72%	87%
REMEDIATION DATA				
Noncompliant		5	8	4
AE implemented monitoring protocols		4	3	3
AE located documentation to substantiated protocols were implemented		1	5	1
Remediated within 30 days		4	7	3
Remediated within 31-60 days		1	0	1
Remediated within 61-90 days		0	1	0
Remediated in >90 days		0	0	0
# Remediated		5	8	4
% of AEs remediated		100%	100%	100%

Details: The AE Operating Agreement establishes the roles and responsibilities of AEs with respect to functions delegated to them for program administration. AEs may delegate and purchase administrative functions in accordance with the AE Operating Agreement. When AEs delegate or purchase administrative functions, they shall retain responsibility for compliance with the AE Operating Agreement. In addition, AEs are responsible to monitor delegated or purchased administrative functions to ensure compliance with applicable Departmental rules, Waiver requirements, written policies and procedures, and state and federal laws.

ODP receives from each AE annually a list of administrative functions that are delegated or purchased by that AE along with a copy of the monitoring protocol for each delegated or purchased function. On an annual basis, ODP reviews the list of each AE's delegated or purchased functions to verify implementation of the monitoring protocol. If ODP determines that an AE is not implementing monitoring activities as required by the protocol, the AE will be notified and is expected to complete remediation within 30 days. Remediation can be completed by the AE locating missing evidence that documents their implementation of the monitoring protocol and/or by the AE implementing required monitoring protocols and providing ODP supporting evidence. Evidence may include but is not limited to AE correspondence with the entity that carries out the delegated and/or purchased function containing findings of monitoring, records of on-site visits to the entity or entities involved, and corrective actions taken by the entity or entities involved.

Agency Follow-Up and Improvement: Performance of the AEs demonstrates improvement over time and can be attributed to training and targeted technical assistance provided by ODP regional staff in the areas of non-compliance.

Table 1.2 Performance Measure AA.a.i.2

Performance Measure: Number and percent of AEs that maintain, safeguard, and provide access to waiver records as per ODP's expectations. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) *= Number of AEs that maintain, safeguard and provide access to waiver records as per ODP's expectations.* ***Denominator (D)*** *= Number of AEs reviewed.*	N	47	46	44
	D	48	48	48
	% (N/D)	98%	96%	92%
REMEDIATION DATA				
Noncompliant		1	2	4
Documentation located		1	2	4
Remediated within 30 days		1	2	4
# Remediated		1	2	4
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP evaluates whether AEs maintain, safeguard, and provide access to Waiver records according to ODP's policies and procedures. If an AE does not maintain, safeguard, and provide access to Waiver records according to ODP's policies and procedures, the AE is expected to document remediation actions and submit the documentation to ODP within 30 days. Remediation activities may include locating missing evidence of record retention, establishing secure record storage, and training staff on procedures to safeguard access and confidentiality of records.

Table 1.3 Performance Measure AA.a.i.3.

Performance Measure: Number and percent of waiver participants whose category of need for services is reviewed/updated in accordance with the Department's policy and form (currently Prioritization of Urgency of Need for Services [PUNS]). (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants whose category of need for services is reviewed/updated in accordance with the Department's policy and form (currently PUNS).*	N	95	102	103
Denominator (D) = *Number of waiver participants reviewed.*	D	113	107	113
	% (N/D)	84%	95%	91%
Number of PUNS updated late (after service change)		10	1	2
Within 30 days		1	0	2
In > 90 days		9	1	0
Number compliant before remediation		105	103	105
% compliant before remediation		93%	96%	93%
REMEDIATION DATA				
Noncompliant requiring remediation		8	4	8
PUNS update documentation was located and entered into HCSIS		5	1	2
PUNS update was completed and entered into HCSIS		3	2	3
PUNS Created		0	0	2
Participant/Family withdrew request for waiver participation		0	1	0
Participant Deceased		0	0	1
Remediated within 30 days		5	2	5
Remediated within 31-60 days		2	1	0
Remediated within 61-90 days		1	0	0
Remediated in >90 days		0	1	2
Not remediated; referred to appropriate staff for follow-up		0	0	1
# Remediated		8	4	8
% Remediated		100%	100%	100%

Details: Through AEOMP, ODP evaluates AE performance in determining participants' category of need. The Prioritization of Urgency of Need for Services (PUNS) serves to ensure individuals identified for enrollment into the Waiver are assigned a category of need for services in accordance with the Department's policy. ODP generates a report of individuals for whom a category of need for services form (PUNS) has not been completed in a timely manner and makes the report available to AEs monthly. Each AE is responsible to review these reports and work with the applicable SCO to ensure remediation for any situation where a category of need for services form has not been completed and updated within 365 days. Remediation is expected to occur within 30 days and includes completion of category of need for service forms and entry of the information into HCSIS. AEs must summarize the remediation actions taken and provide information to ODP staff.

Participants who are fully served are not identified in this measure. Only those who have active PUNS as a result of a changing service need are considered, leaving few qualifying cases for consideration. Further review shows the non-compliances identified within this extremely limited sample occurred when PUNS forms were not updated within 365 days during SFY 14/15.

Agency Follow-Up and Improvement: During SFY 14/15, a HCSIS system enhancement has been completed that will enable ODP to track historical updates to the PUNS form in HCSIS. With this enhancement, ODP will be able to produce a 365-day tickler report that identifies all participants and shows their active PUNS status, last update and next update due. In addition, the system enhancement will enable users to identify all 30 day updates due based on change in need, providing an opportunity to monitor participant PUNS status in a more timely fashion. This system alert will replace manual tracking and provide for more accurate and reliable identification of PUNS status. ODP plans to operationalize the use of this HCSIS system enhancement and accompanying reporting in the coming months.

Table 1.4 Performance Measure AA.a.i.4.

Performance Measure: Number and percent of eligible applicants having an emergency need or who have been identified as being in reserved capacity status who receive preference in waiver enrollment. Percent = number of eligible applicants having an emergency need or who have been identified as being in reserved capacity status who receive preference in waiver enrollment/number of eligible applicants. (Data Source: Waiver Capacity Management Reports)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of eligible applicants having an emergency need who receive preference in waiver enrollment.*	N	873	1,111	1,085
Denominator = *Number of eligible applicants.*	D	873	1,111	1,085
	% (N/D)	100%	100%	100%

Details: ODP reviews information on individuals added to Intent to Enroll status (individuals who are in the process of being enrolled in the Waiver) to ensure that eligible applicants having an emergency need for services or who have been identified as being in reserved capacity status receive preference in Waiver enrollment. For any individual who does not have emergency status on the waiting list or has not been identified as being in reserved capacity status, ODP reviews the record and/or contacts the AE to determine if the eligible applicant meets emergency criteria or reserved capacity status. The AE is instructed to update the record as necessary and appropriate.

If ODP determines that the individual does not meet emergency or reserved capacity status criteria, ODP will provide technical assistance/training to the AE regarding ODP's Waiver enrollment policies. An AE that continues to fail to make the required corrections or updates to the record or to violate Waiver enrollment policies will be suspended from making Waiver enrollment decisions for a period of 90 days unless otherwise sanctioned by ODP. All requests for enrollment during the suspension period will be processed through an ODP Regional Office.

Table 1.5 Performance Measure AA.a.i.5.

Performance Measure: Number and percent of waiver participants issued fair hearing and appeal rights in accordance with policies and procedures. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants issued fair hearing and appeal rights in accordance with policies and procedures.* ***Denominator =*** *Number of participants reviewed.*	N	366	376	392
	D	386	397	437
	% (N/D)	95%	95%	90%
REMEDIATION DATA				
Noncompliant		20	21	45
Documentation is located and/or ISP was updated		8	6	17
Notification completed of Due Process Rights, ISP is updated, entered in HCSIS		6	12	19
Staff Retrained		2	2	5
ISP signature page updated to reflect notification of Due Process Rights		1	1	2
Participant disenrolled		3	0	2
Remediated within 30 days		17	19	23
Remediated within 31-60 days		3	0	15
Remediated within 61-90 days		0	1	3
Remediated in >90 days		0	1	4
# Remediated		20	21	45
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP determines if Waiver participants in the sample were issued rights to fair hearing and appeals when the participant was determined likely to require an ICF/ID level of care (for participants enrolled within the last twelve months), at the last annual ISP meeting, and at the time of a service change (if a service was reduced, suspended or denied).

If ODP does not locate documentation to substantiate that due process rights were issued in any of the above circumstances, ODP will instruct the AE to locate missing documentation or, when not available, provide written notification of due process rights to the participant/surrogate. The information is recorded in HCSIS or the ISP Signature Page is completed where applicable with a note acknowledging that the notification is late. The AE is expected to document remediation actions and submit the documentation to ODP within 30 days.

Table 1.6 Performance Measure AA.a.i.6.

Performance Measure: Number and percent of final orders issued by the Department's Bureau of Hearings and Appeals ruled in favor of the appellant and implemented within 30 calendar days of the final order. (Data Source: Service Reviews Database)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of final orders issued by the Department's Bureau of Hearings and Appeals ruled in favor of the appellant and implemented within 30 calendar days of the final order.* ***Denominator =*** *Number of final orders issued by the Department's Bureau of Hearings and Appeals ruled in favor of the appellant.*	N	1	0	0
	D	1	0	0
	% (N/D)	100%	N/A	N/A

Details: ODP maintains a log of Fair Hearing requests for Waiver participants. When a Fair Hearing request results in the Department's Bureau of Hearings and Appeals rendering a decision, that information is recorded in the log along with any required action. AEs must ensure that final orders are implemented within the expected timeframe. If orders are not implemented within expected timeframes, AEs will be required to ensure remediation within five calendar days of notification by ODP. AEs will work with SCOs to revise the ISP if necessary or initiate/continue the service. AEs shall notify ODP of the remediation action that has occurred within 10 days. Of the records reviewed for the three years, one appeal was ruled in favor of the individual. In that case, a request for additional respite was authorized in the individual's ISP within 30 days.

Table 1.7 Performance Measure AA.a.i.7.

Performance Measure: Number and percent of AEs that qualify providers using qualification criteria as outlined in the current approved waiver. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of AEs that qualify providers using qualification criteria as outlined in the current approved waiver.* ***Denominator =*** *Number of AEs reviewed.*	N	41	44	42
	D	47	46	45
	% (N/D)	88%	96%	94%
REMEDIATION DATA				
Noncompliant		6	2	3
Remediated by collecting documentation that AE qualified provider in accordance with ODP's standardized procedures		6	2	3
Remediated within 30 days		5	2	2
Remediated within 60 days		1	0	1
# Remediated		6	2	3
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of provider initial and annual provider qualification applications. ODP ensures that each AE reviews provider qualification information using ODP standardized procedures. If an AE does not qualify a provider using ODP standardized procedures, the AE is expected to contact the provider and collect all missing documents within 30 days. If the documentation obtained does not corroborate that the provider

meets qualification standards, the AE documents in HCSIS that the provider does not meet qualification standards and the provider will be prohibited from receiving payments for waiver services. ODP provides training to the AE on the correct application of the provider qualification process. ODP will enhance its monitoring of the AE and if the problem persists, initiate AE sanctions as specified in the AE Operating Agreement.

Providers are qualified by the AE where they provide the most services. As a result, the number of AEs that are counted for this measure changes on an annual basis. During the current waiver cycle, significant improvements were made to standardize the qualification process and offer training for providers. It is apparent that the qualification process is being followed by all AEs with improvement demonstrated over time. In all instances of non-compliance, remediation occurred when AEs produced documentation necessary to support provider qualifications.

Table 1.8 Performance Measure AA.a.i.8.

Performance Measure: Number and percent of AEs that monitor providers using the monitoring processes developed by ODP. (Data Source: AEOMP)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of AEs that monitor providers using the monitoring processes developed by ODP.*	N	41	39	41
Denominator = *Number of AEs reviewed.*	D	46	43	44
	% (N/D)	89%	91%	93%
REMEDIATION DATA				
Noncompliant		5	4	3
Remediated by AEs locating evidence that documents their monitoring of all waiver providers		2	1	2
Remediated by AEs ensuring retraining of staff regarding Provider Monitoring requirements		1	2	1
Remediated by AEs communicating notification of results to provider in writing		2	1	0
Remediated within 30 days		4	1	1
Remediated within 31-60 days		0	3	1
Remediated within 61-90 days		1	0	1
# Remediated		5	4	3
% Remediated		100%	100%	100%

Details: On an annual basis, ODP identifies providers that are scheduled to be monitored using the ODP standardized monitoring process and tools. Upon completion of monitoring for each provider within its jurisdiction, an AE will complete and submit a standardized monitoring tool to ODP. Through the AEOMP, ODP reviews a sample of providers monitored by each AE. If an AE does not complete provider monitoring using the monitoring processes developed by ODP, the AE will remediate identified deficiencies and notify ODP of the completion of remediation actions within 30 days. Providers are monitored on a two-year cycle. As a result, the number of AEs that are counted in this measure changes on an annual basis.

In Pennsylvania, there are 48 Administrative Entities (AEs). Within the provider monitoring process, all providers are monitored within a two-year period which makes up one cycle. For this measure, the denominator consists of all AEs who have been identified as a Lead AE (an AE

assigned to monitor a provider) for the SFY. At times, there are AEs who are not considered a Lead AE due to the small size of their respective county and/or the distribution of providers in Year 1 and Year 2 of the cycle. Therefore, these AEs would not have to conduct any monitoring activities as a Lead AE for a particular SFY, thus creating a variance in the denominator by SFY.

VI. State Provides Financial Accountability for the Waiver

The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.
Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74~ SMM 2500; SMM 4442.8; SMM 4442.10

The state substantially meets the assurance.

Subassurance a: The State provides evidence that financial oversight exists to assure that claims are coded and paid for in accordance with reimbursement methodology specified in the approved waiver.

Table 6.1 Performance Measure FA.a.i.1.

Performance Measure: Number and percent of claims paid using correct reimbursement rates. (Data Source: PROMISe™)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of claims paid using correct reimbursement rates.* ***Denominator =*** *Number of claims paid.*	N	1,880,804	2,129,153	2,225,610
	D	1,880,804	2,129,153	2,225,610
	% (N/D)	100%	100%	100%

Table 6.2 Performance Measure FA.a.i.2.

Performance Measure: Number and percent of claims paid for participants who were eligible on the date the service was provided. (Data Source: PROMISe™)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of claims paid for participants who were eligible on the date the service was provided.* ***Denominator =*** *Number of claims paid.*	N	1,880,804	2,129,153	2,225,610
	D	1,880,804	2,129,153	2,225,610
	% (N/D)	100%	100%	100%

Table 6.3 Performance Measure FA.a.i.3.

Performance Measure: Number and percent of claims paid where services were consistent with those in service plans. (Data Source: PROMISe™)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of claims paid where services were consistent with those in service plans.* ***Denominator =*** *Number of claims paid.*	N	1,880,804	2,129,153	2,225,610
	D	1,880,804	2,129,153	2,225,610
	% (N/D)	100%	100%	100%

Details: The reimbursement logic built into Pennsylvania's Medicaid Management Information System (MMIS) ensures that providers are not paid more than the rate that is stored in the system, that Waiver participants were eligible for services on the date the service was provided, and that services paid are authorized in the Waiver participant's approved ISP. A problem may be identified by a provider or providers, contractors, AE, ODP staff, or OMAP.
The ODP Claims Resolution Section conducts research to identify if (a) the reimbursement rate was incorrect; (b) the eligibility information was incorrect, or (c) services paid are inconsistent with the services authorized in the ISP. If a problem is validated, appropriate corrective action is identified promptly. Systemic errors are corrected in collaboration with the MMIS contractor and, if necessary, with the contractor who supports HCSIS. Rates or eligibility information entered into the system incorrectly are corrected and the universe of paid claims that was processed using the incorrect information is identified. In the rare event that an overpayment is made, ODP will immediately notify the provider and credit any overpayment on the next PROMISe billing cycle.

Thus the FMAP amount charged via the MMIS system to CMS is rapidly corrected, generally within one month or less after an overpayment is discovered. If an underpayment is made, the provider is contacted to void and resubmit in order to obtain the increased rate.

Table 6.4 Performance Measure FA.a.i.4.

Performance Measure: Number and percent of providers whose claims are supported by documentation that services were delivered. (Data Source: Provider Monitoring)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of providers whose claims are supported by documentation that services were delivered.*	N	192	218	246
Denominator = *Number of providers reviewed.*	D	237	269	301
	% (N/D)	81%	81%	82%
REMEDIATION DATA				
Noncompliant		42	51	55
Missing documentation was located		5	7	4
Remittance of corrected billing		21	35	48
Staff Training		5	4	1
Revision of policy/procedures		3	3	1
Termination of Provider Agreement		2	0	0
Billing suspended pending investigation of fraud by Attorney General		1	0	0
Referral to BPI		1	0	0
Provider withdrew		2	2	1
Within 30 days		24	32	31
Within 60 days		5	11	13
Within 90 days		6	6	6
Beyond 90 days		7	2	5
Remediated		42	51	55
% Remediated		100%	100%	100%
Noncompliant		24	32	31

Details: In addition to the set of comprehensive edits and audits incorporated into the State's CMS certified Medicaid Management Information System (MMIS), PROMISe™, ODP has outlined a Provider Monitoring process which includes On-Site Review of providers by AEs. AEs review 50% of providers annually so that over a two-year cycle, 100% of providers are reviewed on-site. The monitoring tool contains a question in reference to documentation to support claims for services. A single instance of noncompliance results in a "finding". If a provider did not have authorized services during the prior fiscal year, the provider would not have paid claims for that year and would not have claims to review. Therefore, the question regarding documentation to support claims for services is not applicable.

Agency Follow up and Improvement: ODP has focused efforts on refining the monitoring process and clarifying claim documentation expectations to stakeholders which includes a Progress Note template which has been approved for use as a resource document. ODP has communicated via Informational Packet #035-14, issued 6/13/14 "Waiver Service Claim Documentation and Remediation Process" which addresses actions that should be taken when issues arise with Waiver claims submission or supporting documentation. This communication also describes the process to follow if the reviewer is concerned that the findings during an on-site review may be the result of fraud. This includes referrals to the Bureau of Program Integrity.

ODP has communicated via Informational Memo #062-15, issued 7/31/15, "Enforcement Actions against Noncompliant ODP Intellectual Disability Waiver Providers" what sanctions may be taken based on ODP's authority in the 55 Pa. Code Chapter 51 regulations and has established a sanction policy to articulate the actions that could be taken in the event of repeat non-compliance. These actions include withholding, disallowing, suspending or recouping payment or future payment, disallowance of new service locations, services or new individuals.

CMS Findings and Recommendations

Evidence provided by the state demonstrates that the assurance has been met. Documentation submitted by the State indicates appropriate systems in place to ensure that there is an adequate system for assuring financial accountability.