Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

<table>
<thead>
<tr>
<th>Service Specification</th>
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</thead>
<tbody>
<tr>
<td><strong>Service Title:</strong> Support Coordination</td>
</tr>
</tbody>
</table>

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):
Supports Coordination is a mandatory service that involves the primary functions of locating, coordinating, and monitoring needed services and supports for waiver participants. Locating services and supports consists of assistance to the participant and his or her family in linking, arranging for, and obtaining services specified in an individual support plan, including needed medical, social, habilitation, education, or other needed community services. Locating activities include all of the following, in addition to the documentation of activities:

- Participate in the ODP standardized needs assessment process to inform the planning process;
- Facilitate the completion of additional assessments, based on participants’ unique strengths and needs, for planning purposes;
- Coordinate the development of the plan;
- Assist the participant and his or her family in securing and choosing willing and qualified providers;
- Refer participants to unpaid, informal, generic, and specialized services and supports;
- Provide information to participants on fair hearing rights and assist with fair hearing requests when needed and upon request;
- Assist participants in gathering and maintaining documents required for certification and recertification of level of care; and
- Problem resolution to ensure that participants gain access to needed services and entitlements.

Coordinating consists of development and ongoing management of the individual support plan in cooperation with the participant, his or her family, and providers of service. Coordinating activities include all of the following, in addition to the documentation of activities:

- Use a person centered planning approach and a team process to develop the participant’s individual support plan to meet the participant’s needs in the least restrictive manner possible;
- Periodic review of the plan with the participant;
- Coordinate support planning with providers of service;
- Contact with family, friends, and other community members to coordinate the participant’s natural support network;
- Facilitate the resolution of barriers to service delivery and consistency of services; and
- Disseminate information and support to participants and others who are responsible for
planning and implementation of services.

Monitoring consists of ongoing contact with the participant and his or her family, and oversight, to ensure services are implemented as per the participant’s plan. Monitoring activities include all of the following, in addition to the documentation of activities:

- Monitor the health and welfare of participants through regular contacts at the minimum frequency outlined in Appendix D-2-a;
- Monitor support plan implementation through monitoring visits with the participant, at the minimum frequency outlined in Appendix D-2-a;
- Visit with the participant’s family and providers of service for monitoring of health and welfare and support plan implementation;
- Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health and welfare of participants;
- Assess participant progress;
- Assess participant and/or family satisfaction with services;
- Arrange for modifications in services and service delivery, as necessary, and modify the plan accordingly;
- Ensure that services are appropriately documented, and are authorized, prior to implementation;
- Ensure that service objectives and outcomes are consistent with the participant’s needs and goals; and
- Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and participant rights.

Supports Coordination also includes information and assistance to help participants decide whether to select participant direction of services, and assistance for participants who opt to direct services. Activities include all of the following, in addition to the documentation of activities:

- Provide participants with information on participant direction, including the potential benefits and risks associated with directing services, during the planning process and upon request;
- Assist with the transition to the participant direction service delivery model if the participant is interested in this model, and ensure continuity of services during transition;
- Assist the participant in designating a surrogate, as desired, as outlined in Appendix E-1-f; and
- Provide support to participants who are directing their services, such as assistance with individual budgeting.

The following activities are excluded from Supports Coordination as a waiver service:

- Outreach that occurs before an individual is determined to be part of the “target population”;
- Intake for purposes of determining whether an individual has mental retardation and qualifies for Medical Assistance;
- Direct Prevention Services;
- General information to participants, families, and the public that is not on behalf of a waiver participant;
- Travel expenses of the Supports Coordinator outside of eligible service functions;
- Services otherwise available under Medicaid and Early Intervention;
- Delivery of medical treatment and other specialized services including physical or psychological examinations or evaluations;
- The actual cost of the provision of the service that the Supports Coordinator links, arranges, or obtains on behalf of the participant;
- Conducting Medicaid eligibility certification or recertification, intake processing, Medicaid pre-admission screening for inpatient care, prior authorization for Medicaid services, and Medicaid outreach (methods to inform or persuade individuals to enter into care through the Medicaid system); and
- Assistance in locating and/or coordinating burial services for a deceased participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

<table>
<thead>
<tr>
<th>Provider Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Category(s)</td>
</tr>
<tr>
<td>(check one or both):</td>
</tr>
<tr>
<td>Individual. List types:</td>
</tr>
<tr>
<td>Agency. List the types of agencies:</td>
</tr>
</tbody>
</table>

Specify whether the service may be provided by (check each that applies):
- Legally Responsible Person
- Relative/Legal Guardian

Provider Qualifications (provide the following information for each type of provider):

<table>
<thead>
<tr>
<th>Provider Type:</th>
<th>License (specify)</th>
<th>Certificate (specify)</th>
<th>Other Standard (specify)</th>
</tr>
</thead>
</table>

Minimum Qualifications of Supports Coordination Organizations:
1. Is in compliance with 55 PA Code Chapter 6201.12 (b)(3), (4), (5), (6), (7), and (10)(i), (ii), (iii), and (iv).
2. Does not directly provide Consolidated or Person/Family Directed Support (P/FDS) Waiver Services other than Supports Coordination.
3. Does not directly provide Mental Retardation Base Services.
4. Board composition may only include a maximum of 25% of members who may have a formal relationship with a direct provider of Consolidated, P/FDS, or MR Base Services.
5. Does not function as a Health Care Quality Unit, Independent Monitoring Team, Intermediary Service Organization, or Assessment vendor for the developmental programs system, or function as a subcontractor of one of these types of organizations.
6. Has at least one key management or executive personnel who qualify as a Qualified Mental Retardation Professional.
7. Utilizes a 24-hour response system that ensures access to organization personnel for response to emergency or crisis situations.
8. Conducts a standard ODP customer satisfaction survey at least once every two
1. Has an agreement with the local intake entity to ensure consistent referrals of eligible individuals, unless this function is provided by a unit of the Supports Coordination Organization as a non-covered service.

2. Has a signed Medical Assistance Provider Agreement with ODP.

3. Must meet the requirements for operating a not-for-profit, profit, or governmental organization in Pennsylvania.

4. Has a process for utilizing the Home and Community Services Information System (HCSIS) to document and perform Supports Coordination activities.

5. Agrees to enter and update provider-related information in HCSIS and PROMISe.

6. Agrees to comply with rate setting and billing requirements for Supports Coordination services, which includes utilizing a process for reconciliation of claims and rebilling.

7. Will accept the current Supports Coordination reimbursement rate as payment in full, and will not charge the individual or any other source for Supports Coordination services.

8. Has a signed standard Waiver Provider Contract with the applicable Administrative Entity(ies) until June 30, 2009 as per the current AE Operating Agreement.

9. Compliant with HIPAA.

10. Will cooperate with provider monitoring conducted by the applicable Administrative Entity(ies) or ODP or its agents.

11. Will cooperate with and assist, as needed, ODP and any state and federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting Medicaid fraud and abuse.

12. Has a process to review the utilization of Supports Coordination services.

13. Has a Quality Management strategy consistent with the approved waiver.

14. Compliant with all applicable ODP policy bulletins.

15. Until June 30, 2009, agrees to immediately notify the applicable administrative entity(ies) and ODP in writing of any noncompliance or failure to meet any of these qualification criteria. Effective July 1, 2009, notification must be made to ODP.

16. Cooperates with Health Care Quality Units, independent monitoring teams, and other
external monitoring conducted by ODP business agents.

25. Agrees to commit to transitioning planning in the event of termination of qualification by either the organization or ODP.

Minimum Qualifications for Supports Coordinators who provide services through a Supports Coordination Organization:

1. New Supports Coordinators receive ODP-required orientation.
2. Supports Coordinators and Supports Coordinator Supervisors with a caseload receive a minimum of 40 hours of training each calendar year, comprised of the required annual ODP-sponsored training sessions and local training.
3. Supports Coordinator Supervisors without a caseload receive the required annual ODP-sponsored training.
4. Supports Coordinators conduct monitoring at the minimum frequency requirements outlined in D-2-a of this Waiver.
5. Supports Coordinators and Supports Coordinator Supervisors with a caseload meet the following minimum requirements:
   a. Are at least 18 years of age;
   b. Have criminal background checks;
   c. Have child abuse clearances; and
   d. Meet the following minimum educational and experience requirements:
      i. A bachelor’s degree, which includes or is supplemented by at least 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social science;
      ii. Two years experience as a County Social Service Aide 3 and two years of college level course work, which include at least 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social service; or
      iii. Any equivalent combination of experience and training which includes 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social service and one year of experience as a County Social Services Aide 3 or similar position performing paraprofessional case management functions.
## Verification of Provider Qualifications

<table>
<thead>
<tr>
<th>Provider Type:</th>
<th>Entity Responsible for Verification:</th>
<th>Frequency of Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>ODP</td>
<td>Annually</td>
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</table>

### Service Delivery Method

- [ ] Participant-directed as specified in Appendix E
- [✓] Provider managed