

Attachment 2

Service Definitions Narrative for Consolidated Waiver, Person/Family Directed Support Waiver, Administrative Services, and Base/Waiver Ineligible Services

General Comments

The purpose of this document is to outline the services that are available through the Consolidated Waiver and Person/Family Directed Support (P/FDS) Waivers, administrative funding, and base/waiver ineligible funding. Consolidated and P/FDS services are available to individuals with mental retardation aged three and older. However, services funded by the waivers are **not** available to individuals while they are living or staying in public or private Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR), nursing homes, residential treatment facilities, correctional facilities, drug and alcohol facilities, or hospitals. Base-funded services, which are funded through state-only dollars, are available to individuals with mental retardation of any age.

The Office of Developmental Programs (ODP) is the Program Office within the Pennsylvania Department of Public Welfare with responsibility for administering funding and developing policies and requirements related to mental retardation services. ODP functions as the State Medicaid Agency for the Consolidated and P/FDS Waivers. As the State Medicaid Agency, ODP is the authority responsible for the administration and the supervision of the Waivers, and to issue policies, rules, and regulations relative to the Waivers. ODP is also responsible for ensuring sufficient funds are available to meet the needs of individuals enrolled in the Consolidated and P/FDS Waivers.

The cost of P/FDS services provided to any individual in a fiscal year, with the exception of Supports Coordination services, may not exceed the funding cap established in the current P/FDS waiver, or amendment. There is no similar cap associated with the Consolidated Waiver. All services must be provided to meet the current, individualized needs of the individual to protect the individual's health and welfare. The need for services must be established through assessment processes and needed services and supports must be identified through a person centered planning process and documented in Individual Support Plans (ISPs). All services and supports must be cost-effective and efficient.

ISPs are based on the self-determination philosophies and concepts of *Everyday Lives*, Person-Centered Planning and Positive Approaches and capture the true meaning of working together to empower the individual to dream, plan and create a shared commitment for his or her future. Self Determination gives individuals

receiving services more control and responsibility in choosing how they want to live their lives, have emerged through the grassroots efforts of individuals receiving those services and their families, friends and advocates to enhance, and better define the planning process. *Everyday Lives* includes the core values of Choice, Control, Quality, Community Inclusion, Stability, Accountability, Safety, Individuality, Relationships, Freedom, Success, Contributing to the Community, Collaboration, and Mentoring. These values exemplify the attributes that everyone with or without disabilities should have in their lives. Person-Centered Planning focuses on the individual's strengths, choices, and preferences. Positive Approaches defines the context in which clinical and behavioral interventions are provided to teach individuals the skills they need to make safe and appropriate choices.

Licensed residential services, which include Child Residential Services, Community Residential Rehabilitation Services for the Mentally Ill, Community Homes for Individuals with Mental Retardation, and Family Living Homes, are **only** available through the Consolidated Waiver and base/Waiver ineligible funds.

Waiver-funded services discussed in this document cannot be provided to individuals in their residences if the residences are provider-owned, leased, or rented and serve more than ten individuals. Services may be provided to individuals who live in licensed residential settings established prior to January 1, 1996, with an approved program capacity to provide services to ten or fewer unrelated individuals, or in homes established on or after January 1, 1996, with an approved program capacity to provide services to four or fewer unrelated individuals. Services may be provided to individuals who reside in ICFs/MR of ten beds or less that have converted to waiver-funded homes.

Use of Modifiers

In recognition of requirements to protect individuals' health and welfare, to enable the achievement of the purpose of the service, to individualize services, and to account for differences in service delivery regulations and/or methods specific to different service settings, some of the services have unique sets of modifiers. The modifiers consist of multiple levels of staff-to-individual support ratios or support by staff that may have had special training and/or experience. While providing a framework through which the health and welfare needs of individuals can be protected and outcomes can be achieved, modifiers also provide options to individuals and families who may need enriched services and/or may choose more creative programs made possible through lower staff-to-individual ratios.

Services by Relatives, Legal Guardians, and Legally Responsible Individuals

Relatives/legal guardians may be paid to provide services funded through the Waivers on a service-by-service basis. A relative is any of the following who have not been assigned as legal guardian for the individual with mental retardation: a parent (natural or adoptive) of an adult, a stepparent of an adult child, grandparent, brother, sister, half-brother, half-sister, aunt, uncle, niece, nephew, adult child or stepchild of a parent with mental retardation, or adult grandchild of a grandparent with mental retardation. For the purposes of this policy, a legal guardian is a person not affiliated with a provider agency who has legal standing to make decisions on behalf of a minor or adult (e.g. a guardian who has been appointed by the court). These individuals may be paid to provide Waiver services when the following conditions are met:

- The service provided is not a function that the relative or legal guardian would normally provide for the individual without charge in the usual relationship among members of a nuclear family;
- The service would otherwise need to be provided by a qualified provider of services funded under the waiver; and
- The service is provided by a relative or legal guardian who meets the qualification criteria that are established by ODP in Appendix C-3 of the approved Waivers.

Services that relatives/legal guardians can provide are limited to the following: Home and Community Habilitation (Unlicensed), Supported Employment, Transportation (Mile), and Home Finding. Relatives/legal guardians who are not the individual's primary caregiver may also provide Supports Broker Services and **waiver-funded** Respite Services when the conditions listed above are met. Relative/legal guardians may provide **base-funded** respite services only when the relative/legal guardian does not live in the same household as the individual, and when the conditions above are met.

Legally responsible individuals may be paid to provide services funded through the Waivers on a service-by-service basis. A legally responsible individual is a person who has legal obligation under the provisions of law to care for another person, including parents of minors (natural or adoptive), spouses, and legally-assigned relative caregivers of minor children. These individuals may be paid to provide Waiver services when the following conditions are met:

- The service is considered extraordinary care, which means it is not part of the supports the legally responsible individual is ordinarily obligated to provide;
- The service would otherwise need to be provided by a qualified provider of services funded under the waiver; and

- The service is provided by a legally responsible individual who meets the qualification criteria that are established by ODP in Appendix C-3 of the approved Waivers.

Services that legally responsible individuals can provide are limited to the following: Home and Community Habilitation (Unlicensed), Supported Employment - Job Finding and Job Support, Transportation (Mile), and Home Finding.

Payments to legally responsible individuals, relatives, and legal guardians who provide services are made through a Financial Management Services (FMS) Organization, previously known as Intermediary Service Organizations (ISOs), or a provider agency. Payments are based upon time sheets submitted by the legally responsible individual/relative/legal guardian to the FMS or agency, which are consistent with the individual's authorized services on their individual support plan. The AE and the FMS or agency is responsible to ensure that payments are only made for services that are authorized on the participant's approved ISP. The legally responsible individual, relative, or legal guardian who provides services must document those services as per bulletin 00-07-01, *Provider Billing Documentation Requirements for Waiver Services* (or any approved revisions).

Home and Community Services

Home and Community Services are direct services provided to individuals who need assistance in the acquisition, retention, or improvement of skills related to living and working in the community and to prevent institutionalization. Waiver-funded services must be documented as per 00-07-01, *Provider Billing Documentation Requirements for Waiver Services*, or any approved revisions.

Services that are solely diversional (i.e. related to leisure or entertainment activities) or recreational in nature are not available through the Home and Community Services definitions. Community activities may, however, serve a habilitative or therapeutic purpose for individuals, based on the activity and the individual's individualized needs. If a community activity serves a habilitative or therapeutic purpose, home and community based services may be used to fund the staff coverage necessary for the individual to participate in the activity. The cost of the activity (i.e. entrance fees, tickets, etc.) is not eligible for reimbursement as part of the home and community based service, but may be paid for through private funds or non-waiver dollars.

Waiver-funded home and community services may be provided to residents of certain residential settings, such as Domiciliary Care Homes, when these homes have a licensed capacity of ten or fewer unrelated persons and when the home is located in a local community in noncontiguous and non-campus settings. Home and community services may be provided to Personal Care Home (PCH) residents who receive base-funded services and to participants in the P/FDS Waiver with a move-in and enrollment date **prior to** July 1, 2008. PCH residents with a move-in and enrollment date **on or after** July 1, 2008, are only eligible for the P/FDS Waiver if the PCH has a licensed capacity of ten or fewer unrelated persons. Waiver-funded home and community services may not be used to fund the services that the PCH or Domiciliary Care Home is required to provide to the individual.

Services may be provided in combination with other services as per the Home and Community Services Grid (Attachment 3). Additional clarification on the provision of transportation in combination with other services is as follows:

Residential Habilitation: Transportation is provided as a component of the Residential Habilitation service, and is therefore reflected in the rate for Residential Habilitation. Providers of (unlicensed and licensed) Residential Habilitation are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their individual support plans (ISPs). This includes transportation to and from day habilitation and employment services.

Unlicensed Home and Community Habilitation: Agency-based providers of Unlicensed Home and Community Habilitation are responsible for the full range

of transportation services needed by the individuals they serve to participate in services and activities specified in their ISPs. For these providers, transportation costs are included in the Habilitation rate.

Day Habilitation: Agency-based providers of Prevocational Services, Transitional Work Services, or Licensed Day Habilitation may only incorporate transportation costs into their rate when the transportation is necessary for involving individuals in activities that are integral to these services. An example is transportation that originates from a provider site to a community activity or function that is part of the overall program of activities of the provider. This does *not* include transportation to and from the individual's home (including licensed and unlicensed residential settings) and the day service.

Transportation included in the rate for Unlicensed Home and Community Habilitation, Residential or Day Habilitation, or Prevocational or Transitional Work Services may NOT be duplicated through the inclusion of the transportation service on an individual's ISP.

Travel Policy

Certain Home and Community Servicesⁱ may be provided in Pennsylvania, or anywhere in the United States, during temporary travel under the following conditions:

1. The travel plans are reviewed and discussed as part of an ISP team meeting, and the team identifies safeguards to protect the individual's health and welfare during travel;
2. The roles and responsibilities of the individual receiving services and the staff person(s) for home and community services are the same during travel as at home;
3. ODP bears no responsibility for travel costs of either the individual or the staff person(s);
 - a. The individual is responsible to fund their travel costs through private or non-system funds.
 - b. Travel costs for staff person(s) may be funded through private funds of family members of the individual receiving services or non-system funds generated through fundraising efforts or other means.
4. An individual is limited to previously authorized hours for vacations and other optional travel. For example, an individual who typically receives 32 units of home and community habilitation per day while at home is limited to 32 units of habilitation per day while traveling;
5. All service and program requirements, such as provider qualification criteria and documentation of services, apply during the period of travel. This includes the requirement for licensed residential services that the permanent residential setting must be located and licensed in Pennsylvania; and

6. The provision of home and community services during travel is limited to no more than 30 consecutive calendar days.

AEs shall ensure that this travel policy is explained to all waiver participants at the time of waiver enrollment, and reviewed annually at the time of the planning meeting.

Certain Home and Community services may be provided by qualified providers that are based in states contiguous to Pennsylvania. These services include: Education Support, Unlicensed Home and Community Habilitation, Licensed Day Habilitation, Prevocational Services, Respite, Supported Employment, Nursing, Therapy Services, Supports Broker, Assistive Technology, Behavioral Support, Companion, Home Accessibility Adaptations, Vehicle Accessibility Adaptations, Home Finding, Specialized Supplies, Transitional Work Services, and Transportation.

Home and Community Habilitation (Unlicensed)

This is a direct service (face-to-face) provided in home and community settings to protect health and welfare to assist individuals in acquiring, maintaining, and improving self-help, domestic, socialization, and adaptive skills. Services consist of support in the general areas of self-care, communication, fine and gross motor skills, mobility, therapeutic activitiesⁱⁱ, personal adjustment, relationship development, socialization, and use of community resources. When services are provided by agency-based providers, this service also includes transportation services necessary to enable the individual to participate in the home and community habilitation service, in accordance with the individual's ISP. This service may not be provided in licensed settingsⁱⁱⁱ, and is not a licensed residential service; for residential services, see Residential Home and Community Habilitation Licensed Homes and Unlicensed Homes.

Home and Community Habilitation is a service that may be provided to individuals in their own home or in other community settings not subject to licensing regulations.

Home and Community Habilitation consists of services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation may be provided up to 24 hours a day based on the needs of the individual, to protect the individual's health and welfare. Camp day or overnight may only be provided under respite.

Through the provision of this service individuals learn, maintain, or improve skills through their participation in a variety of everyday life activities. They learn and use skills in the context of these activities; this is considered a functional

approach to the delivery of services. These activities must be necessary for individuals to live in the community, to live more independently, or to be more productive and participatory in community life. Services must be provided in a manner that protects the individual's health and welfare.

In addition to supporting individuals in activities typically associated with those occurring in their homes and their community, the Home and Community Habilitation service may also be used to provide staff assistance to support individuals in the following ways:

1. Habilitation provided in home and family settings that are *not* subject to Department licensing or approval, when the provider of habilitation meets established requirements/qualifications.
2. Support that enables the individual to access and use community resources such as instruction in using transportation, translator and communication assistance, and services to assist the individual in shopping and other necessary activities of community life.
3. Support that assists the individual in developing or maintaining financial stability and security, such as plans for achieving self-support; general banking; personal and estate planning; balancing accounts; preparing income taxes; and recordkeeping.
4. Support that enables an individual to participate in community projects, associations, groups, and functions, such as support that assists an individual to participate in a volunteer association or a community work project.
5. Support that enables an individual to visit with friends and family in the community.
6. Support that enables an individual to participate in public and private boards, advisory groups, and commissions.
7. Support that enables the individual to exercise rights as a citizen, such as assistance in exercising civic responsibilities.
8. Support provided during overnight hours when the individual needs the habilitation service to protect their health and welfare. If the individual only needs supervision during overnight hours, the appropriate service is Companion Services.

There may be multiple uses of this service with different providers within an individual's ISP as long as there is documented need and there are no conflicts or overlaps with regard to day and/or time of service. For example, an individual may participate in activities that are community-based and receive Home and Community Habilitation from 6:00 PM to 9:00 PM, Monday through Friday to satisfy an outcome of participating in a community resource. The same individual could also be provided with a Home and Community Habilitation service that is home-based, scheduled Monday through Friday from 11:30 AM to 12:30 PM to support him/her in achieving an outcome of independent meal preparation.

This service may not overlap with or duplicate Companion Services. Home and Community Habilitation (Unlicensed) and Companion Services have a combined maximum limit of 24 hours (96 15-minute units) per participant per calendar day. This service should be coordinated with any service(s) that may be provided in the Specialized Therapies and Nursing Services category to ensure consistency in services to individuals across service settings.

Licensed Day Habilitation, Prevocational Services, Transitional Work Services, Supported Employment (direct service), and Home and Community Habilitation (unlicensed) services may not overlap in terms of day and time.

The code and service units for Unlicensed Home and Community Habilitation provided in private homes and unlicensed community settings follow:

W7057		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes ^{iv}
W7058		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7059		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7060		Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7060	U2	Level 3 – Services by a Parent	The provision of the service at a staff-to-individual ratio of 1:1 rendered by a parent who is not considered an hourly employee in accordance with Internal Revenue Services and Pennsylvania Labor & Industry requirements.	15 minutes
W7061		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed ^v .	15 minutes
W7068		Level 4	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7069		Level 4 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.	15 minutes

Unlicensed Residential Habilitation

These are direct and indirect services provided to protect the health and welfare of individuals by assisting them in acquiring, retaining, and improving self-help, socialization, and adaptive skills. Services consist of support in the general areas of self-care, communication, fine and gross motor skills, mobility, therapeutic activities, personal adjustment, relationship development, socialization, and use of community resources. This service also includes transportation services that

are necessary to enable the individual to access services and resources outlined in the ISP, including transportation to and from day or employment services. The Unlicensed Residential provider is not responsible for transportation to community activities for which another provider is responsible. The Unlicensed Residential provider is not responsible for transportation when the individual is at a Day Habilitation, Prevocational, or Transitional Work service.

Unlicensed Residential Habilitation may be provided in provider-owned, rented, leased homes and family living homes:

- Under 55 Pa. Code §6400.3(f)(7) (for Community Homes), which excludes community homes that serve three or fewer individuals with mental retardation 18 years of age or older who need a yearly average of 30 hours or less direct staff contact per week per home; or
- Under 55 Pa. Code §6500.3(f)(5) (for Family Living Homes), which excludes family living homes that provide room and board for one or two individuals with mental retardation 18 years of age or older who need a yearly average of 30 hours or less direct training and assistance per week per home from the agency, county mental retardation program, or the family.

All waiver-funded homes must be integrated and dispersed in the community in noncontiguous locations and may not be located on campus settings.

The Unlicensed Residential Home may only be located in Pennsylvania. The code and service units for Unlicensed Residential Habilitation in Community Homes follow:

W7078		One-Individual Home, Eligible	The eligible portion of the unlicensed community residential service provided in a one-individual home.	Day ^{vi}
W7079		One-Individual Home, Ineligible	The ineligible portion of the unlicensed community residential service provided in a one-individual home.	Day
W7080		Two-Individual Home, Eligible	The eligible portion of the unlicensed community residential service provided in a two-individual home.	Day
W7081		Two-Individual Home, Ineligible	The ineligible portion of the unlicensed community residential service provided in a two-individual home.	Day
W7082		Three-Individual Home, Eligible	The eligible portion of the unlicensed community residential service provided in a three-individual home.	Day
W7083		Three-Individual Home, Ineligible	The ineligible portion of the unlicensed community residential service provided in a three-individual home.	Day

The code and service units for Unlicensed Residential Habilitation in Family Living Homes follow:

W7037		One-Individual Home, Eligible	The eligible portion of the unlicensed family living provided in a one-individual home.	Day
W7038		One-Individual Home, Ineligible	The ineligible portion of the unlicensed family living provided in a one-individual home.	Day
W7039		Two-Individual Home, Eligible	The eligible portion of the unlicensed family living provided in a two-individual home.	Day
W7040		Two-Individual Home, Ineligible	The ineligible portion of the unlicensed family living provided in a two-individual home.	Day

Residential Home and Community Habilitation – Licensed Homes

These are direct (face-to-face) and indirect services provided in provider-owned, rented/leased, or operated (i.e. licensed and unlicensed Family Living homes) licensed residential settings. Services are provided to protect the health and welfare of individuals by assisting them in acquiring, retaining, and improving self-help, socialization, and adaptive skills. Services consist of support in the general areas of self-care, communication, fine and gross motor skills, mobility, therapeutic activities, personal adjustment, relationship development, socialization, and use of community resources. This service also includes transportation services that are necessary to enable the individual to access services and resources outlined in the ISP, including transportation to and from day or employment services. The Licensed Residential provider is not responsible for transportation to community activities for which another provider is responsible. The Licensed Residential provider is not responsible for transportation when the individual is at a Day Habilitation, Prevocational, or Transitional Work service.

Services must meet regulatory requirements of homes licensed under 55 Pa.Code Chapters 3800, 5310, 6400, or 6500. Waiver-funded Licensed Residential Habilitation may **not** be provided in Personal Care Homes. Waiver-funded Licensed Residential Habilitation may only be provided in Domiciliary Care Homes if the home is jointly licensed by the Department of Public Welfare and certified by the local Area Agency on Aging (see Bulletin 00-00-05).

All waiver-funded homes must be integrated and dispersed in the community in noncontiguous locations, and may not be located on campus settings. Waiver-funded services may not be provided to individuals who live in licensed residential settings established on or prior to January 1, 1996, with a approved program capacity to provide services to more than ten unrelated individuals, or in homes established after January 1, 1996, with a approved

program capacity to provide services to more than four unrelated individuals. Services may be provided to individuals who reside in previously certified ICFs/MR of ten beds or less that have been converted to waiver-funded homes. The size limitations do not apply to base-funded residential services.

Residential Habilitation – Licensed Residential Habilitation services are only available through the Consolidated Waiver and base funds.

Services consist of support to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Residential habilitation is provided for 24 hours a day based on the need of the individual receiving services.

The Licensed Residential Home may only be located in Pennsylvania.

Residential Enhanced Staffing

Residential Enhanced Staffing may be utilized in Waiver-funded residential settings and involves three possible components, which are treated as add-ons to the traditional Residential service:

- The provision of the residential habilitation by licensed nurses;
- The provision of supplemental habilitation staffing, as part of the licensed residential service, to meet temporary medical or behavioral needs of the individual; and/or
- The provision of home and community based services other than habilitation (ex. Physical therapy) as part of the residential service to meet the needs of individuals living there.

The continued need for Residential Enhanced Staff should be reviewed at least annually as part of the ISP process. Each of these types of Residential Enhanced Staffing is accounted for in different ways, as follows:

Residential Habilitation Provided by Licensed Nurses

When residential habilitation is provided by licensed nurses, the individual’s ISP must accurately reflect the residential service by including the correct transaction code (ex. W6094 for a 3-individual Community Home) and the following nursing modifier:

	<p>TD (For habilitation provided by RNs)</p> <p>TE (for habilitation provided by LPNs)</p>	<p>Nursing Modifier</p>	<p>The provision of habilitation by nursing staff due to medical needs of the individual. To bill this service, the modifier can be used in concert with the transaction code for the eligible portion of the service configurations above.</p>	<p>Day</p>
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Supplemental Habilitation

When home and community habilitation is used to temporarily supplement the residential habilitation service to meet the **short-term** unique behavioral or medical needs of an individual, the individual's ISP must reflect the residential service and the supplemental habilitation. For example, an individual is discharged from the hospital with additional needs, and requires a temporary addition of two hours of one-to-one staffing each day. Please note that because Supplemental Habilitation is a temporary service, it may only be authorized for a maximum of 12 consecutive calendar months. This time period will allow providers to be compensated for the additional staff costs until the costs can be reflected in the rate for the Residential Habilitation service. ODP will request information from providers during the rate setting process, in order to calculate such adjustments in the Residential Habilitation rate.

The appropriate code for the Residential Habilitation service should be included, as well as the needed number of units of the following supplemental habilitation service:

W7070		Supplemental Habilitation	The provision of habilitation to supplement the Basic residential service to meet the unique needs of the individual.	Hour
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Other Home and Community Based Services

The residential provider may provide other non-habilitation home and community based services authorized in the individual's ISP that are not a required component of a licensed residential provider (ex. Physical therapy). The provision of such services may not duplicate services integral to a residential provider's licensure, and must be included on the individual's ISP and billed discretely as the other home and community based service. Furthermore, the provider must meet the respective provider qualification criteria. For example, if the individual requires Physical Therapy, the individual's ISP will include the appropriate code for the Physical Therapy, as well as the needed number of units of Physical Therapy. If the residential provider is providing the Physical Therapy, they should be listed on the ISP as the provider of both the Residential Habilitation and the Physical Therapy services. The residential provider will bill discretely for both Residential Habilitation and Physical Therapy. The individual will retain free choice of provider regardless of the provider of the home and community based service.

Bed Reservation Days

Bed Reservation Days may be utilized for temporary absences in Waiver-funded residential settings. Temporary absences are defined as absences in which an individual is expected to return to the residential setting. The bed reservation

days allow reimbursement of a Residential Habilitation provider for temporary absences of individuals enrolled in the Consolidated Waiver. ODP will provide reimbursement for the eligible and ineligible portions of the residential habilitation day rate as detailed below. The eligible and ineligible portions of the residential habilitation day rates are defined by the codes in the service definitions for the types of Residential Habilitation. This policy is created to ensure that the individual may return to the same residential facility after a therapeutic leave or hospital stay.

Temporary Absence

As a result of the change to a day unit, the definition of residential habilitation in the Consolidated Waiver will include payment to a residential habilitation provider for temporary absence due to therapeutic leave or medical leave. A temporary absence is defined as an absence in which an individual is expected to return to the residential site. The purpose of this policy is to ensure that the individual may return to the same residential site after therapeutic or medical leave. The eligible and ineligible portions of the residential habilitation day rates will be defined by the codes in the service definitions.

Therapeutic Leave

A therapeutic leave day is defined as an absence from the residential habilitation site to visit with a relative or friend, including absence due to vacation when the individual is not accompanied by a staff person from the residential site, and is, therefore, not receiving services from the residential provider. Based on the definition of a day unit, the first day of absence for therapeutic leave is defined as 12 to 24 hours of continuous absence within a 24 hour period between 12:00 a.m. and 11:59 p.m. when the individual is not accompanied by, or receiving services from, the residential provider. If the individual's therapeutic leave begins immediately after the day program, then the absence begins when the day program ends. Below are several examples of therapeutic leave.

Example 1 - The individual leaves the residential site for therapeutic leave at 8:00 p.m. on Friday evening and returns at 3:00 p.m. on Saturday. The individual has only used one day of therapeutic leave even though the individual has been out of the home on two different calendar days. On Friday, the individual was gone from 8:00 p.m. to 11:59 a.m. representing 4 hours of leave. On Saturday, the individual was gone from 12:00 a.m. to 3:00 p.m. representing 15 hours of leave. Since the individual was gone for 15 hours on Saturday, which is between 12 to 24 hours of continuous absence, this is one day of therapeutic leave.

Example 2 - The individual leaves the residential site for therapeutic leave at 10:00 a.m. on Saturday and returns at 9:00 p.m. on Saturday. The individual has been out of the home for 11 hours of continuous absence from 12:00 a.m. to

11:59 p.m. on that day. Since the first day of therapeutic leave must equal 12 to 24 hours, a therapeutic leave day has not been used.

Example 3 - The individual leaves the residential site for therapeutic leave at 10:00 a.m. on Saturday and returns at 4:00 p.m. on Sunday. The individual has been out of the home for 30 hours of continuous absence. On Saturday, the individual was gone from 10:00 a.m. to 11:59 p.m. which represents 14 hours of absence. On Sunday, the individual was gone from 12:00 a.m. to 4:00 p.m., which represents 16 hours of absence. This is two days of therapeutic leave.

Example 4 – The individual leaves the residential site at 9:00 a.m. on Friday to attend the day program. The individual goes to visit his or her parents at 4:00 p.m., leaving directly from the day program. The individual returns to the residential site at 4:00 p.m. on Sunday. Because the therapeutic leave starts when the individual leaves the day program, on Friday, the individual was gone from 4:00 p.m. to 11:59 p.m., which represents 8 hours of continuous absence, which is less than 12 to 24 continuous hours. On Saturday, the individual was gone from 12:00 a.m. to 11:59 p.m., which represents 24 hours of absence. On Sunday, the individual was gone from 12:00 a.m. to 4:00 p.m. which represents 16 hours of absence. Since the individual was gone 8, 24 and 16 hours on Friday, Saturday, and Sunday, respectively, this is two days of therapeutic leave.

DPW will provide payment to the provider for 100% of the eligible and 100% of the ineligible portion of the residential habilitation day rate for up to a maximum of 48 bed reservation days in a fiscal year for therapeutic leave.

DPW may make payment for therapeutic leave days beyond 48 days based on criteria developed in consultation with representatives of the various stakeholders. Requests for payment beyond 48 days will be reviewed on a case by case basis. DPW will evaluate utilization of therapeutic leave on a periodic basis to determine the need to revise the payment policy for therapeutic leave.

Payment will not be made for a therapeutic leave day if the provider uses the bed for an alternative purpose during a temporary absence. For example, DPW will not pay for therapeutic leave when the provider uses the bed to provide respite services to another individual.

Medical Leave

For temporary absence when an individual has been admitted into a nursing facility, acute care general hospital, rehabilitative hospital, rehabilitation unit of an acute care general hospital, or short term stay in a rehabilitation facility, psychiatric hospital, or psychiatric unit of an acute care general hospital and is expected to return to the residential site, DPW will provide payment to the provider at 100% of the eligible portion and 100% of the ineligible portion of the residential habilitation day rate for the first 30 days. After the 30th day, DPW will

continue to provide payment to the provider at 100% of the eligible portion and 60% of the ineligible portion of the residential habilitation day rate for the entire length of the hospitalization, rehabilitation or nursing facility stay.

After DPW has received cost data from providers for fiscal year 07/08, and in consultation with representatives of the various stakeholders, it will evaluate whether to revise the 60% for ineligible costs for future fiscal years.

The first day of absence for medical leave is the date of admission to the facility regardless of the length of the absence. The provider will be paid for medical leave until the day before the date of discharge. On the date of discharge, the provider will be paid for a residential habilitation day, not medical leave, regardless of the number of hours of service provided on that day. Below are several examples of medical leave:

Example 1 – An individual is taken to an emergency room (ER) at 7:00 p.m. and a residential worker accompanies the individual while in the ER. The individual is there until 3:00 a.m. and returns to the residential site at 4:00 a.m. This does not count as a medical leave day since the individual was attended by a residential habilitation worker and was not admitted to the hospital.

Example 2 – An individual is taken to the emergency room at 10:00 p.m. on Saturday and admitted at 12:00 a.m. on Sunday. The individual is discharged back to the same residential site on Tuesday at 8:00 a.m. Medical leave starts on Sunday, the date of admission, and is used until the day before the date of discharge, which is Monday in this case. The provider would bill Tuesday, the date of discharge, as a residential habilitation day.

Payment will not be made for a medical leave day if the provider uses the temporary vacancy for an alternative purpose during a temporary absence. For example, DPW will not pay for medical leave when the provider is using the vacancy to provide respite services to another individual.

Documentation

The Supports Coordinator should document *planned* therapeutic leave days in the Individual Support Plan (ISP) through an Outcome Statement related to the therapeutic leave. If an individual uses unplanned therapeutic leave, an update to the ISP is only required if the ISP does not already include an appropriate Outcome Statement. The therapeutic and medical leave days should not be included separately in the 'Service Details' page. The information in the 'Service Details' page of the ISP should indicate the *total* number of residential days, including therapeutic and medical leave. For example, if an individual plans to receive 344 days of Residential Habilitation in the home, 14 days of therapeutic leave, and 7 days of medical leave, the 'Service Details' page of the ISP should note 365 days of Residential Habilitation under the appropriate code (ex. W6090

and W6091 for a 1-individual Community Home). The Supports Coordinator should update the ISP through a General Update as a result of planned or unplanned medical leave, and indicate any changes resulting from the leave (e.g., changes in medication).

Claims submission

Temporary absence days will be billed using modifiers as specified in the final FY 09/10 service definitions. To receive payment for either therapeutic or medical leave, the residential provider must submit claims using the appropriate code and modifier to differentiate between residential habilitation, therapeutic leave, and medical leave. For example, if an individual receives ten days of residential habilitation in the home, three days of therapeutic leave and one day of medical leave in a two-week period, the claim must identify all three separately, through the use of modifiers (ten units of W6090, ten units of W6091, three units of W6090 UC, three units of W6091 UC, one unit of W6090 UD and one unit of W6091 UD).

The code and service units for Bed Reservation days follow:

	UC	Bed Reservation for Therapeutic Leave	This modifier must be added to the eligible and ineligible service codes for the Residential Habilitation the person is receiving, when the person is temporarily absent from the residential setting for therapeutic leave.	Day
	UD	Bed Reservation for Medical Leave	This modifier must be added to the eligible and ineligible service codes for the Residential Habilitation the person is receiving, when the person is temporarily absent from the residential setting for a stay in a hospital or rehabilitation facility.	Day

Permanent Vacancy

A permanent vacancy is defined as one in which the individual is no longer eligible for and is therefore dis-enrolled from the Consolidated Waiver because the individual is not expected to return to the residential habilitation site due to death, moving out of the State of Pennsylvania, or permanent placement in an alternative setting such as an ICF/MR or a nursing home.

For permanent vacancies in Waiver-funded Residential settings, DPW will pay the provider at 100% of the eligible portion and 60% of the ineligible portion of the residential habilitation day rate for the first 60 days. During the 60-day period following a permanent vacancy, DPW will perform a thorough review per the waiver capacity management policy, to determine whether or not the needs of the individuals remaining in the residential habilitation site have changed after the permanent vacancy.

Subject to the sufficient appropriation of funds, DPW will, at the request of the provider, continue to pay after the 60th day of a permanent vacancy so long as the provider has made a good faith effort to work with an individual regarding placement, but the placement does not occur for reasons beyond the control of the provider (e.g., delays in referrals from the administrative entity or relating to the submission of information to HCSIS, delays in eligibility determination, delays in the scheduling of ISP meetings, or delays caused by the choice of the individual or the representative of the individual to not go forward with the placement).

DPW will not pay for a permanent vacancy if the provider uses the permanent vacancy for an alternative purpose such as respite, if the individual moves to another residential habilitation site operated by the same provider, if there is a planned move from a residential habilitation site operated by one provider to a site operated by another provider^{vii}, if the provider does not cooperate with the placement process, or if the provider is under restriction for quality of care issues.

After DPW has received cost data from providers for Fiscal Year 07/08 and in consultation with representatives of the various stakeholders, it will evaluate whether to revise the 60% payment of ineligible costs for future Fiscal Years.

W7056		Permanent Vacancy for Residential Services	This code is used to bill for permanent vacancies in residential habilitation settings, as per ODP's vacancy policy.	Day
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Eligible Settings

DPW will pay for temporary and permanent absences in Waiver-funded residential settings licensed under 55 Pa. Code Chapter 6400, or exempt from licensing under 55 Pa. Code §6400.3(f)(7), in accordance with the above provisions.

DPW will pay for temporary absences for Waiver participants in Family Living Homes licensed under 55 Pa. Code Chapter 6500 or exempt from licensing under 55 Pa. Code §6500.3(f)(5), children's residential settings licensed under 55 Pa. Code Chapter 3800 and CRR's licensed under 55 Pa. Code Chapter 5310, in accordance with the above provisions.

DPW will pay for permanent vacancies in residential settings licensed under 55 Pa. Code Chapter 3800 or Chapter 5310 only with ODP approval and only retrospectively, if the vacancy is filled with a waiver participant.

Child Residential Services (The residential section of 55 Pa.Code Chapter 3800, Child Residential and Day Treatment Facilities)

The 55 Pa.Code Chapter 3800 services that may be funded through the Consolidated Waiver are limited to residential service settings. Child residential services provided in secure settings, detention centers, mobile programs, outdoor programs, and residential treatment facilities accredited by JCAHO (Joint Commission on Accreditation of Healthcare Organizations) may not be funded through the Consolidated Waiver.

The code and service units for Child Residential Services follow:

W7010		One-Individual Home, Eligible	The eligible portion of the child residential services provided in a one-individual home.	Day
W7011		One-Individual Home, Ineligible	The ineligible portion of the child residential services provided in a one-individual home.	Day
W7012		Two-Individual Home, Eligible	The eligible portion of the child residential services provided in a two-individual home.	Day
W7013		Two-Individual Home, Ineligible	The ineligible portion of the child residential services provided in a two-individual home.	Day
W7014		Three-Individual Home, Eligible	The eligible portion of the child residential services provided in a three-individual home.	Day
W7015		Three-Individual Home, Ineligible	The ineligible portion of the child residential services provided in a three-individual home.	Day
W7016		Four-Individual Home, Eligible	The eligible portion of the child residential services provided in a four-individual home.	Day
W7017		Four-Individual Home, Ineligible	The ineligible portion of the child residential services provided in a four-individual home.	Day
W7018		Five-to-Ten-Individual Home, Eligible	The eligible portion of the child residential services provided in a five-to-ten-individual home if the home was established prior to January 1, 1996.	Day
W7019		Five-to-Ten-Individual Home, Ineligible	The ineligible portion of the child residential services provided in a five-to-ten-individual home.	Day

Community Residential Rehabilitation Services for the Mentally III (CRRS), (55 Pa.Code Chapter 5310)

CRRS are characterized as transitional residential programs in community settings for individuals with chronic psychiatric disabilities. This service is full-care CRRS for adults with mental retardation and mental illness. Full-care CRRS for adults is a program that provides living accommodations for individuals who are psychiatrically disabled and display severe community adjustment problems.

A full range of personal assistance and psychological rehabilitation is provided for individuals in a structured living environment. **Host homes are excluded.**

The code and service units for Community Residential Rehabilitation Services follow:

W7020		One-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a one-individual home.	Day
W7021		One-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a one-individual home.	Day
W7022		Two-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a two-individual home.	Day
W7023		Two-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a two-individual home.	Day
W7024		Three-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a three-individual home.	Day
W7025		Three-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a three-individual home.	Day
W7026		Four-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a four-individual home.	Day
W7027		Four-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a four-individual home.	Day
W7028		Five-to-Ten-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a five-to-ten-individual home, if the home was established prior to January 1, 1996.	Day
W7029		Five-to-Ten-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a five-to-ten-individual home.	Day

Family Living Homes (55 Pa.Code Chapter 6500)

Family Living Homes are somewhat different than other licensed homes as these settings provide for lifesharing arrangements. Individuals live in host family homes and are encouraged to become contributing members of the family unit. Family living arrangements are chosen by individuals and families in conjunction with host families and in accordance with the individual's needs. Licensed Family Living Homes are limited to homes in which one or two individuals with mental retardation who are not family members or relatives of family members are living. The primary family living provider is eligible for substitute care to provide relief for the provider, based on the needs of the individual and the family

living provider. The costs of substitute care are included in the rate for the family living service.

The code and service units for Licensed Family Living Homes follow:

		Adult Family Living		
W7291		One-Individual Home, Eligible	The eligible portion of the licensed family living provided in a one-individual home.	Day
W7292		One-Individual Home, Ineligible	The ineligible portion of the licensed family living provided in a one-individual home.	Day
W7293		Two-Individual Home, Eligible	The eligible portion of the licensed family living provided in a two-individual home.	Day
W7294		Two-Individual Home, Ineligible	The ineligible portion of the licensed family living provided in a two-individual home.	Day
		Child Family Living		
W7295		One-Individual Home, Eligible	The eligible portion of the licensed family living provided in a one-individual home.	Day
W7296		One-Individual Home, Ineligible	The ineligible portion of the licensed family living provided in a one-individual home.	Day
W7297		Two-Individual Home, Eligible	The eligible portion of the licensed family living provided in a two-individual home.	Day
W7298		Two-Individual Home, Ineligible	The ineligible portion of the licensed family living provided in a two-individual home.	Day

Community Homes for Individuals with Mental Retardation (55 Pa.Code Chapter 6400)

A licensed community home is a home licensed under 55 Pa.Code Chapter 6400 where services are provided to individuals with mental retardation. A community home is defined in regulations as, “A building or separate dwelling unit in which residential care is provided to one or more individuals with mental retardation....”

The code and service units for Licensed Residential Habilitation in Community Homes follow:

W6090		One-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a one-individual home.	Day
W6091		One-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a one-individual home.	Day
W6092		Two-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a two-individual home.	Day

W6093		Two-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a two-individual home.	Day
W6094		Three-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a three-individual home.	Day
W6095		Three-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a three-individual home.	Day
W6096		Four-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a four-individual home.	Day
W6097		Four-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a four-individual home.	Day
W6098		Five-to-Ten-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a five-to-ten-individual home, if the home was established prior to January 1, 1996.	Day
W6099		Five-to-Ten-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a five-to-ten-individual home.	Day
	UA	Semi Independent Living Modifier	The provision of the licensed residential service provided in a semi-independent living home as defined by §6400.271-275.	Day

Companion Services

Companion services are provided to individuals living in private residences for the limited purposes of providing supervision and **minimal** assistance that is focused solely on the health and safety of the adult individual (18 and older) with mental retardation. This service is not available to people who are residing in Unlicensed or Licensed Residential Habilitation settings. Companion services are used in lieu of habilitation services to protect the health and welfare of the individual when a habilitative outcome is not appropriate or feasible (i.e. when the individual is *not* learning, enhancing, or maintaining a skill). This service can be used for asleep hours when only supervision or non-medical or non-habilitative care is needed to protect the safety of the individual with mental retardation. For example, a companion can be used during overnight hours for an individual who lives on their own but does not have the ability to safely evacuate in the event of an emergency. This service can also be used to supervise individuals during socialization or non-habilitative activities when necessary to ensure the individual's safety. Companions may supervise and provide minimal assistance with daily living activities, including grooming, health care, household care, meal

preparation and planning, and socialization. This service may not be provided at the same time as any other direct service.

This service is not available for people residing in agency-owned, rented/leased, or operated (i.e. licensed and unlicensed Family Living homes) homes. Companion and Home and Community Habilitation (Unlicensed) Services have a combined maximum limit of 24 hours (96 15-minute units) per participant per calendar day.

The code and service units for Companion Services follow:

W1724		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes
W1725		Level 1	The provision of the service at a staff-to-individual ratio of <1:6 to 1:3.5.	15 minutes
W1726		Level 2	The provision of the service at a staff-to-individual ratio of <1:3.5 to >1:1.	15 minutes
W1727		Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes

Day Services

ODP requires that individuals are provided with flexibility in the utilization of day services (to include Unlicensed Home and Community Habilitation utilized for community-based day services, Licensed Day Services, Prevocational Services, Supported Employment, and Transitional Work Services). This flexibility may include the use of different day service options to meet a individual’s needs (ex. Supported Employment three days per calendar week combined with Transitional Work Services two days per calendar week), as well as timely revisions to ISPs to accommodate changes in day service needs. The goal is to provide individuals with unique day service combinations to meet individuals’ needs, and help individuals to achieve employment and volunteering outcomes. The flexibility provides a safety net often expressed by families as needed in the event an individual is not successful in maintaining employment.

Licensed Day Services

Licensed Day Habilitation (55 Pa.Code Chapter 2380), Adult Training Facilities and Older Adult Daily Living Centers (6 Pa.Code Chapter 11)

This is a direct service (face-to-face) that must meet the regulatory requirements of 55 Pa.Code Chapter 2380 (Adult Training Facilities) or 6 Pa.Code Chapter 11 (Older Adult Daily Living Centers). Services consist of supervision, training, and support in general areas of self-care, communication, community participation, and socialization. Areas of emphasis include: therapeutic activities, fine and gross motor development, mobility, personal adjustment, use of community

resources, and relationship development. The service also includes transportation that is an integral component of the service, for example, transportation to a community activity. The Licensed Day provider is not, however, responsible for transportation to and from an individual's home, unless the provider is designated as the transportation provider in the individual's ISP. In this case, the transportation service must be billed as a discrete service.

The following services have a combined total limitation of 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year: Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Supported Employment. Licensed Day Habilitation, Prevocational Services, Transitional Work Services, Supported Employment (direct service), and Home and Community Habilitation (unlicensed) services may not overlap in terms of day and time.

The code and service units for Adult Training Facilities follow:

W7072		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes
W7073		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7074		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7075		Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7076		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.	15 minutes
W7035		Level 4	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7036		Level 4 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.	15 minutes

Please note: If an individual requires 1:1 or 2:1 staffing during licensed day habilitation, the day service provider is responsible to provide the staffing. Needed day staffing may not be provided by the individual's residential, unlicensed habilitation, or other non-day habilitation provider, and these types of services may not be used to supplement the licensed day habilitation service.

The code and service units for Older Adult Daily Living Centers follow:

W7094		Licensed Day Habilitation Services – Older Adult Daily Living Centers (6, Pa.Code Chapter 11)	This service is made available to older individuals with mental retardation in licensed Older Adult Daily Living Centers.	15 minutes
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Prevocational Service (55 Pa.Code Chapter 2390), Vocational Facilities

This is a direct service (face-to-face) that must meet the regulatory requirements of 55 Pa.Code Chapter 2390 (Vocational Facilities). This service is provided to assist individuals in developing skills necessary for placement in a higher level vocational program and ultimately into competitive employment. The service may be provided as facility-based employment, occupational training, vocational evaluation, a vocational facility, or a work activities center. Facility-based employment focuses on the development of competitive worker traits through the use of work as the primary training method. Occupational training is used to teach skills for a specific occupation in the competitive labor market, and includes personal and work adjustment training that is designed to develop appropriate worker traits and teach the understanding of the expectations of a work environment. Vocational evaluation involves the use of planned activities, systematic observation, and testing to accomplish a formal assessment of the individual, including identification of service needs, potential for employment, and identification of employment objectives. A vocational facility is a premise where habilitative employment or employment training is provided to one or more individuals with disabilities. A work activities center is a program focusing on behavioral and/or therapeutic techniques to enable individuals to attain sufficient vocational, personal, social, independent living skills to progress to a higher level vocational program. The service also includes transportation that is an integral component of the service, for example, transportation to a work activity. The Licensed Prevocational provider is not, however, responsible for transportation to and from an individual's home, unless the provider is designated as the transportation provided in the individual's ISP. In this case, the transportation service must be billed as a discrete service.

Handicapped employment as defined in Title 55, Chapter 2390 may not be funded through the waivers.

This service may not be funded through either waiver or through base allocation if it is available to individuals through a program funded under Section 110 of the Rehabilitation Act of 1973, as amended, or section 602 (16) and (17) of the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the individual's file to satisfy assurances that the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 as amended and the IDEA.

The following services have a combined total limitation of 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year: Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Supported Employment. Licensed Day Habilitation, Prevocational Services, Transitional Work Services, Supported Employment (direct service), and Home

and Community Habilitation (unlicensed) services may not overlap in terms of day and time.

The code and service units for Prevocational Service follow:

W7087		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:15.	15 minutes
W7088		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:15 to 1:7.5.	15 minutes
W7089		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:7.5 to >1:1.	15 minutes
W7090		Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7091		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.	15 minutes
W7092		Level 4	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7093		Level 4 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with a staff member who is licensed or degreed.	15 minutes

Please note: If an individual requires 1:1 or 2:1 staffing during prevocational services, the prevocational provider is responsible to provide the staffing. Needed day staffing may not be provided by the individual's residential, unlicensed habilitation, or other non-prevocational service provider, and these types of services may not be used to supplement the prevocational service.

Waiver-Funded Supports Coordination

The following definition and procedure code for Supports Coordination applies only to those Supports Coordination services funded through the Consolidated and P/FDS Waivers.

Supports Coordination is a critical 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 (ISP), including needed medical, social, habilitation, education, or other needed community services. Activities included under the locating function include all of the following, in addition to the documentation of activities:

- Participate in the ODP standardized needs assessment **process** to inform development of the ISP, including any necessary ISP updates;
- Facilitate the completion of additional assessments, based on participants' unique strengths and needs, for planning purposes and ISP

development in order to address all areas of needs and the participant's strengths and preferences;

- Coordinate the development of the ISP;
- Assist the participant in identifying people to serve as part of the ISP team, and offer support to invite other people who may contribute valuable information during the planning process;
- Assist the participant and his or her family in identifying and choosing willing and qualified providers;
- Inform participants about unpaid, informal, generic, and specialized services and supports that are necessary to address the identified needs of the participant and to achieve the outcomes specified in the ISP;
- Provide information to participants on fair hearing rights and assist with fair hearing requests when needed and upon request; and
- Assist participants in gaining access to needed services and entitlements, and to exercise civil rights.

Coordinating consists of development and ongoing management of the ISP in cooperation with the participant, his or her family, members of the ISP team, and providers of service. Activities included under the coordinating function 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 ISP to meet the participant's needs in the least restrictive manner possible;
- Use information from the ODP standardized needs assessment, as well as any additional assessments completed based on the unique needs of the participant, to develop the ISP to address all of the participant's needs;
- Periodic review of the ISP with the participant, including update of the ISP at least annually and whenever a participant's needs change;
- Periodic review of the standardized needs assessment through a face-to-face visit with the participant, at least annually or more frequently based on changes in a participant's needs, to ensure the assessment is current;
- Coordinate support planning with providers of service to ensure consistency of services;
- Coordinate with other program areas as necessary to ensure all areas of the participant's needs are addressed;
- 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 civil rights; 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 their family, and oversight, to ensure services are implemented as per the participant's plan.

Activities included under the monitoring function 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 of the Consolidated or P/FDS Waiver;
- Monitor ISP implementation through monitoring visits with the participant, at the minimum frequency outlined in Appendix D-2-a of the Consolidated or P/FDS Waiver;
- Visit with the participant's family, when applicable, 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;
- Evaluate participant progress;
- Monitor participant and/or family satisfaction with services;
- Arrange for modifications in services and service delivery, as necessary to address the needs of the participant, and modify the ISP accordingly;
- Ensure that services are appropriately documented in HCSIS on the ISP;
- Work with the authorizing entity regarding the authorization of services;
- Communicate the authorization status to ISP team members, as appropriate;
- Validate that service objectives and outcomes are consistent with the participant's needs and desired outcomes;
- Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and participant rights; and
- Participate in activities related to Independent Monitoring for Quality, such as obtaining consent to participate from the participant, preparing survey information, and follow up activities ("closing the loop").

In addition to locating, coordinating, and monitoring, Supports Coordination also includes providing information and assistance in order 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^{viii}, as desired, as outlined in Appendix E-1-f of the Consolidated or P/FDS Waiver; and

- Provide support to participants who are directing their services, such as assistance with managing participant-directed services specified in the ISP.

The following activities are **excluded** from Supports Coordination as a billable Waiver service:

- Outreach that occurs before an individual is enrolled in the Waiver;
- Intake for purposes of determining whether an individual has mental retardation and qualifies for Medical Assistance;
- Direct Prevention Services, which are used to reduce the probability of the occurrence of mental retardation resulting from social, emotional, intellectual, or biological disorders;
- General information to participants, families, and the public that is not on behalf of a waiver participant;
- Travel expenses of the Supports Coordinator may not be billed as a discrete unit of service;
- Services otherwise available under Medicaid and Early Intervention;
- Services that constitute the administration of foster care programs;
- Services that constitute the administration of another non-medical program such as child welfare or child protective services, parole and probation functions, legal services, public guardianship, and special education;
- Direct delivery of medical, educational, social, or other services
- Delivery of medical treatment and other specialized services including physical or psychological examinations or evaluations;
- The actual cost of the direct services other than Supports Coordination that the Supports Coordinator links, arranges, or obtains on behalf of the participant;
- Transportation provided to participants to gain access to medical appointments or direct Waiver services other than Supports Coordination;
- Representative payee functions;
- 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 or other services for a deceased participant.

Supports Coordination services may not duplicate other direct Waiver services.

Waiver-funded Supports Coordination services may only be provided to Consolidated and P/FDS participants. This service is limited to a maximum of 300 units per individual per fiscal year for Consolidated Waiver participants, and 200 units per individual per fiscal year for P/FDS Waiver participants. The unit

limitations may be extended by the appropriate ODP Regional Office based on individual needs.

The code and service units for Supports Coordination Services follow:

W7210		Supports Coordination	Locating, coordinating, and monitoring needed services and supports for waiver participants.	15 minutes
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Supports Broker Services (previously known as Personal Support Services)

This is a direct (face-to-face) and indirect service to individuals with mental retardation in arranging for, developing, and managing the services they are self-directing through either employer authority (hiring/managing workers) or budget authority (determining worker salaries, shifting funds between approved services and/or providers). Services are provided to assist individuals in identifying immediate and long-term needs, developing community-based options to meet those needs, and accessing identified supports and services. Services also involve practical skills training and information for individuals and surrogates related to directing and managing services. This service is limited to:

- Assistance in identifying and sustaining a personal support network of family, friends, and associates to meet individual needs;
- Assistance in arranging for and effectively managing generic community resources and informal supports to meet individual needs;
- Assistance at planning meetings to ensure the individual's access to needed quality community resources;
- *In depth* practical skills training for individuals and surrogates related to self-direction and management of qualified support service workers. Training is limited to employer responsibilities (e.g. hiring, managing, and terminating workers; reviewing and approving timesheets; problem solving; conflict resolution);
- Assistance to the individual in managing, monitoring, and reviewing their participant directed budget;
- Development of back-up plans in the event of emergencies and/or unexpected worker absences;
- Training to the individual to help them recognize reportable incidents and help them report the incidents to the Supports Coordinator or provider as required;
- Assistance with paperwork related to the individual's employer responsibilities as the employer of record or co-employer of support service workers;

- Assistance with budgeting, including review and evaluation of monthly expenditure reports; and
- Providing detailed information and training to individuals about: person centered planning and how it is applied, risks and responsibilities related to self-direction, free choice of willing and qualified providers, individual rights, and use of community^{ix} and natural supports^x.

This service is limited to a maximum of 1040 units per individual per fiscal year based on a 52-week year. *This service is limited to individuals who are self-directing their services through employer and/or budget authority.*

Supports brokers must work collaboratively with the individual’s supports coordinator. The role of the Supports Coordinator continues to involve the primary functions of locating, coordinating, and monitoring of waiver services; while the Supports Broker assists individuals and families with being able to self-direct their support. It is important to understand that each role is vital to the support of the individual and their family. It is also important to understand that Supports Coordinators also assist individuals and families with self-directing their support, however, not necessarily at the level of intensity that is needed by many. Supports Broker Services are different from Supports Coordination and Supports Brokers may not replace the role or perform the functions of a Supports Coordinator; no duplicate payments will be made.

Supports Broker Services may not be provided by agency providers that provide other direct Waiver services or administrative services (for example, a Health Care Quality Unit, an Independent Monitoring Program, or a Financial Management Services Organization).

The code and service units for Supports Broker Services follow:

W7096		Supports Broker Services	Direct and indirect services to individuals who are self-directing their services through either employer authority (hiring/managing workers) or budget authority (determining worker salaries, shifting funds between approved services and/or providers). Services are provided to assist individuals in planning, organizing, and managing community resources and supports and workers. This service is limited to a maximum of 1040 units per individual per fiscal year based on a 52-week year.	15 minutes
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Employment Services

Supported Employment Services

Supported Employment Services are direct and indirect services that are provided in community employment work sites with co-workers who do not have disabilities for the purposes of finding and supporting individuals in competitive jobs of their choice. Individuals must receive minimum wage or higher.

Supported Employment Services consist of paid employment for individuals who, because of their disabilities, need intensive support to perform in a work setting. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment is provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by the individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported Employment Services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 as amended, or IDEA. Documentation must be maintained in the file of each individual receiving these services to satisfy the state assurance that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 as amended or IDEA.

Federal Financial Participation through the waivers may not be claimed for incentive payments, subsidies, or unrelated vocational expenses such as the following:

- a. Incentive payments made to an employer of individuals receiving services to encourage or subsidize the employer's participation in a supported employment program;
- b. Payments that are passed through to individuals receiving supported employment; or
- c. Payments for vocational training that are not directly related to an individual's supported employment program.

Supported Employment Services consist of two components: job finding and job support. Job finding may include interview assistance, employer outreach and orientation, resume preparation, job searching, and preparation for job tasks. Other examples of activities that may be associated with job finding include participation in individual planning for employment; development of job seeking skills; development of customer-specific job skills; job analysis; support to learn job tasks; consultation with the Office of Vocational Rehabilitation (OVR), benefits counseling agencies, and provider networks under Ticket to Work on

behalf of an individual; assistance in beginning a business; and outreach with prospective employers on behalf of the individual including consultation on tax advantages and other benefits.

Job support consists of training individuals in job assignments, periodic follow-up and/or ongoing support with individuals and their employers. The service must be necessary for individuals to maintain acceptable job performance and work habits including assistance in learning new work assignments, maintaining job skills, and achieving performance expectations of the employer. Other examples of activities that may be associated with job support include participation in individual planning for employment, direct intervention with an employer, employment related personal skills instruction, support to relearn job tasks, training to assist individuals in using transportation to and from work, maintenance of appropriate work and interpersonal behaviors on the job, follow-along services at the work site after OVR funded services are discontinued, and technical assistance and instruction for the individual’s co-workers that will enable peer support.

Ongoing use of the service is limited to support for individuals that cannot be provided by the employer through regular supervisory channels and/or on-the-job resources that are available to employees who are non-disabled. The provision of job finding services must be evaluated at least once every six calendar months by the ISP team, to assess whether the service is assisting the individual with the outcome of finding community employment. If the service is not assisting the individual with this outcome, the ISP team must identify changes to the Supported Employment service to realize this outcome or other service options to meet the individual’s needs. The provision of job support services must be evaluated at least annually, as part of the ISP process, to determine whether the individual continues to require the current level of authorized services. The ISP must be updated, if necessary, to reflect the team’s determination.

The following services have a combined total limitation of 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year: Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Supported Employment. Licensed Day Habilitation, Prevocational Services, Transitional Work Services, Supported Employment (direct service), and Home and Community Habilitation (unlicensed) services may not overlap in terms of day and time.

The code and service units for Supported Employment follow:

W7235		Supported Employment	The provision of services by a staff member with the training and experience to appropriately address the needs of an individual.	15 minutes
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Transitional Work Service

Transitional Work Services consist of supporting individuals in transition to integrated, competitive employment through work that occurs in a location other than a facility subject to 55 Pa.Code Chapter 2380 or Chapter 2390 regulations. Transitional work service options include mobile work force, work station in industry, affirmative industry, and enclave. A Mobile Work Force uses teams of individuals, supervised by a training/job supervisor, who conduct service activities away from an agency or facility. The provider agency contracts with an outside organization or business to perform maintenance, lawn care, janitorial services, or similar tasks and the individuals are paid by the provider. A Work Station in Industry involves individual or group training of individuals at an industry site. Training is conducted by a provider training/job supervisor or by a representative of the industry, and is phased out as the individual(s) demonstrates job expertise and meets established production rates. Affirmative Industry is operated as an integrated business, where disabled and non-disabled employees work together to carry out the job functions of the business. Enclave is a business model where disabled individuals are employed by a business/industry to perform specific job functions while working alongside non-disabled workers. The service also includes transportation that is an integral component of the service, for example, transportation to a work site. The Transitional Work provider is not, however, responsible for transportation to and from an individual's home, unless the provider is designated as the transportation provided in the individual's ISP. In this case, the transportation service must be billed as a discrete service.

This service may not be funded through either waiver or through base allocation if it is available to individuals under a program funded under section 110 of the Rehabilitation Act of 1973, as amended or section 602 (16) and (17) of IDEA. Documentation must be maintained in the file of each individual receiving these services to satisfy the state assurance that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 as amended or IDEA.

The following services have a combined total limitation of 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year: Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Supported Employment. Licensed Day Habilitation, Prevocational Services, Transitional Work Services, Supported Employment (direct service), and Home and Community Habilitation (unlicensed) services may not overlap in terms of day and time.

The code and service units for Transitional Work Service follow:

W7237		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:10 to >1:6.	15 minutes
W7239		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7241		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7245		Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes

Therapy Services

Therapy services include the following:

- Physical therapy provided by a licensed physical therapist based on a prescription for a specific therapy program by a physician. The physical therapist develops a recommended plan of care.
- Occupational therapy by a registered occupational therapist based on a prescription for a specific therapy program by a physician. The occupational therapist develops a recommended plan of care.
- Speech/language therapy provided by an ASHA (American Speech-Language-Hearing Association) certified and state licensed speech-language pathologist upon examination and recommendation by an ASHA certified and state licensed speech-language pathologist or a physician.
- Visual/mobility therapy provided by a trained visual or mobility specialist/instructor based on an evaluation and recommendation by a trained mobility specialist/instructor or a physician.
- Behavior therapy provided by a licensed psychologist or psychiatrist based on an evaluation and recommendation by a licensed psychologist or psychiatrist.

Therapy services are direct services provided to assist individuals in the acquisition, retention, or improvement of skills necessary for the individual to live and work in the community, and must be attached to an individualized outcome. The need for the service must be evaluated on a periodic basis, at least annually as part of the ISP process. This evaluation must review whether the individual continues to require the current level of authorized services and that the service continues to result in positive outcomes for the individual. It is recognized, however, that long-term Therapy services may be necessary due to an individual's extraordinary medical or behavioral conditions. The need for long-term Therapy services must be documented in the individual's ISP.

Physical Therapy, Occupational Therapy, Speech and Language Therapy, and the Behavior Therapies are State Medical Assistance Plan services and may only be funded through the waiver or base allocation when the service

may not be provided under the State Plan or private insurance because the State Plan or insurance limitations have been reached, or when the service is not covered under the State Plan or private insurance. The Supports Coordinator is responsible to verify that the State Plan and/or private insurance limitations have been exhausted prior to funding Therapy services through the Consolidated or P/FDS Waiver. Documentation that the services are not available through the State Plan and/or private insurance must be maintained in the individual's file by the Supports Coordinator. This documentation must be updated on at least an annual basis. The documentation requirement can be met by including detailed information in the person's hard copy file and/or a service note in HCSIS. In addition, a summary of the documentation should be included in the 'Outcome Summary' page of the HCSIS ISP (in the 'Concerns Related to Outcome' field), as the information is needed for authorization. The individual and/or their family and the Supports Coordination must collaborate to obtain documentation to meet this requirement. Examples of acceptable documentation include: summary of a telephone conversation with the individual's insurance provider, excerpts from benefit statements showing that the service is not available, evidence that the individual is no longer eligible for benefits, etc.

Physical Therapy

The Physical Therapy Practice Act (63 P.S. §1301 et seq.) defines physical therapy as follows: "...means the evaluation and treatment of any person by the utilization of the effective properties of physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and rehabilitative procedures including training in functional activities, with or without assistive devices, for the purpose of limiting or preventing disability and alleviating or correcting any physical or mental conditions, and the performance of tests and measurements as an aid in diagnosis or evaluation of function."

The code and service units for Physical Therapy follow:

T2025	GP	Physical Therapy	Physical Therapy service delivered under an outpatient physical therapy plan of care.	15 minutes
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Occupational Therapy

The Occupational Therapy Practice Act (63 P.S. §1501 et seq.) defines occupational therapy as follows: "The evaluation of learning and performance skills and the analysis, selection and adaptation of activities for an individual whose abilities to cope with the activities of daily living, to perform tasks normally performed at a given stage of development and to perform essential vocational tasks which are threatened or impaired by that person's developmental deficiencies, aging process, environmental deprivation or physical, psychological, injury or illness, through specific techniques which include: (1) Planning and

implementing activity programs to improve sensory and motor functioning at the level of performance for the individual's stage of development. (2) Teaching skills, behaviors and attitudes crucial to the individual's independent, productive and satisfying social functioning. (3) The design, fabrication and application of splints, not to include prosthetic or orthotic devices, and the adaptation of equipment necessary to assist patients in adjusting to a potential or actual impairment and instructing in the use of such devices and equipment. (4) Analyzing, selecting and adapting activities to maintain the individual's optimal performance of tasks to prevent disability."

The code and service units for Occupational Therapy follow:

T2025	GO	Occupational Therapy	Occupational Therapy service delivered under an outpatient occupational therapy plan of care.	15 minutes
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Speech and Language Therapy

Services provided by a licensed and American Speech-Language-Hearing Association (ASHA) certified speech-language pathologist including the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification, examination, diagnosis and treatment of conditions of the human speech-language system, and including the examination for, and adapting and use of augmentative and alternative communication strategies, including, assistive devices and assistive technology.

The code and service units for Speech and Language Therapy follow:

T2025	GN	Speech and Language Therapy	Speech/Language Therapy service provided by an ASHA certified and state licensed speech-language pathologist.	15 minutes
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Behavior Therapy

The treatment, by psychological means, of the problem of an emotional nature in which a licensed psychologist or psychiatrist deliberately establishes a professional relationship with an individual, in an attempt to alleviate or ameliorate the emotional distress disturbances, reverse or change maladaptive patterns of behavioral challenges, and promote positive personality growth and development. Such therapy may take the form of individual therapy with the individual and the psychologist or psychiatrist, or in a group setting supervised and directed by the psychologist or psychiatrist.

The code and service units for Individual and Group Behavior Therapy follow:

T2025	HE	Behavior Therapy, Individual	Individual therapy which consists of sessions with the psychologist or psychiatrist designed to increase insight, modify behavior, and provide positive support to the individual to improve social interaction and adjustment.	15 minutes
T2025	HE, HQ	Behavior Therapy, Group	Interactive group psychotherapy consists of group interaction under the supervision and direction of the psychologist or psychiatrist, designed to increase insight, modify behavior and provide positive support for improved social interaction.	15 minutes

Visual/Mobility Therapy

This therapy is for individuals who are blind or have visual impairments. The provision of therapy is for the purpose of increasing individuals' travel skills and/or access to items used in activities of daily living.

This service may include evaluation and assessment of individuals and the environments in which they interact, direct service (face-to-face) to individuals, and training of support individuals. The provision of this service may result in recommendations for adapting environments or purchasing assistive technology.

The code and service units for Visual/Mobility Therapy follow:

W7246		Visual/Mobility Therapy	Visual/Mobility Training for individuals with mental retardation who are blind or have visual impairments.	15 minutes
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Nursing Services

49 Pa.Code Chapter 21 (State Board of Nursing) provides the following service definition for the practice of professional nursing:

"Diagnosing and treating human responses to actual or potential health problems through such service as case finding, health teaching, health counseling, provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The term does not include acts of medical diagnosis or prescription of medical, therapeutic or corrective measures, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the Board, which rules and regulations will be implemented by the Board."

Nursing services provided as a discrete service or as a component of residential or day habilitation must be prior authorized as a needed service by ODP in order to be eligible for waiver and base funding. Prior authorization will be made considering the individual's needs assessment results, other appropriate medical professional assessments, and based on the following medical needs:

- Full- or part-time dependent on a ventilator
- Tracheostomy care for a critical or non-critical airway
- Flushing, hanging medications, providing total parenteral nutrition, trouble shooting central and peripheral lines
- Diminished lung capacity
- Medication administration in nine and ten person licensed homes
- Medication administration or treatments when injections or treatments are necessary only when no other paid or unpaid person is trained and available

Prior authorization must be noted in the ISP on the 'Outcome Summary' page in the 'Relevant Assessments Linked to Outcome' field.

Nursing services are State Medical Assistance Plan services and may only be funded through the waiver or base allocation when the service may not be provided under the State Plan or private insurance because the State Plan or private insurance limitations have been reached, or when the service is not covered under the State Plan or private insurance. The Supports Coordinator is responsible to verify that the State Plan and/or private insurance limitations have been exhausted prior to funding Nursing services through the Consolidated or P/FDS Waiver. Documentation that the services are not available through the State Plan and/or private insurance must be maintained in the individual's file by the Supports Coordinator. This documentation must be updated on at least an annual basis. The documentation requirement can be met by including detailed information in the person's hard copy file and/or a service note in HCSIS. In addition, a summary of the documentation should be included in the 'Outcome Summary' page of the HCSIS ISP (in the 'Concerns Related to Outcome' field) page of the HCSIS ISP, as the information is needed for authorization. The individual and/or their family and the Supports Coordination must work together regarding this requirement. Examples of acceptable documentation include: summary of a telephone conversation with the individual's insurance provider supported by a copy of the coverage policy; excerpts from benefit statements showing that the service is not available; evidence that the individual is no longer eligible for benefits, such as a termination of coverage letter; etc.

The code, service units and modifiers for Nursing Services follow:

T2025	TD	Nursing Service – RN	This service consists of Nursing services within scope of practice.	15 minutes
T2025	TE	Nursing Service – LPN	This service consists of Nursing services within scope of practice.	15 minutes

Behavioral Support

This is a service that includes functional assessment; the development of strategies to support the individual based upon assessment; and the provision of training to individuals, staff, parents and caretakers. Services must be required to meet the current needs of the individual, as documented and authorized in the ISP.

The service is performed under the supervision of an individual with a Masters Degree in Human Services (or a closely related field), and is limited to the following:

- Collection and evaluation of behavioral data;
- Observation of the participant in various settings for the purpose of developing a behavior support plan;
- Collaboration with the participant, their family, and their team for the purpose of developing a behavior support plan that must include positive practices and may not include restraint procedures (physical, chemical, or mechanical) as support strategies;
- Conducting comprehensive functional assessments of presenting issues (e.g. aggression, self-injurious behavior, law offending behavior (sexual or otherwise));
- Development and maintenance of behavior support plans, which utilize positive strategies to support the participant, based on functional behavioral assessments;
- Conducting training related to the implementation of behavior support plans for the participant, family members, and staff;
- Implementation of activities and strategies identified in the participant’s behavior support plan;
- Monitoring implementation of the behavior support plan, and revising as needed;
- Collaboration with the participant, their family, and their team in order to develop positive interventions to address specific presenting issues; and
- Completion of required paperwork related to data collection, progress reporting and development of annual planning material.

Services may be provided in the office of the Behavioral Support professional, the individual’s home, the location of other authorized services, or in local public

community environments necessary for the provision of the Behavioral Support Services. Direct services must be provided on a one-on-one basis.

Behavioral Support services may be provided during the same day and time as other services, but may not duplicate other services. For example, Behavioral Support may be provided during the same day and time as Residential Habilitation, but the Behavioral Support provider may not render services that overlap with the responsibilities of the Residential Habilitation provider.

The code and service units for Behavioral Support follow:

W7095	Behavioral Support	This service includes functional assessment; the development of strategies to support the individual based upon assessment; and the provision of training to individuals, staff, relatives, and caregivers.	15 Minutes
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Waiver-Funded Respite Services

Respite services are direct services that are provided to supervise/support individuals on a short-term basis due to the absence or need for relief of those persons normally providing care. Respite services do not cover the care provided to a minor child when the primary caregiver or legally responsible individual is absent due to work. Services are limited to individuals residing in private homes (their own home or the home of a relative or friend).

Individuals can receive two categories of respite services: 24-hour respite and 15-minute respite. 24-hour Respite is provided for periods of more than 16 hours, and is limited to 30 units (days) per individual per fiscal year, except when extended by the ODP Regional Office based on individual needs. 15-Minute Respite is provided for periods of 16 hours or less, and is limited to 480 (15 minute) units per individual per fiscal year, except when extended by the ODP Regional Office based on individual needs.

Federal and State financial participation through the **waivers** is limited to:

1. Services provided for individuals residing in their own unlicensed home or the unlicensed home of relative, friend, or other family. Respite services are not available for individuals who reside in agency owned, leased/rented, or operated (i.e. licensed and unlicensed Family Living homes) homes.
2. Respite services that are provided by providers or individuals who meet the qualification criteria outlined in the Consolidated and P/FDS Waivers. This requirement extends to all types of respite, including Respite – Camp.

3. Room and board costs associated with respite care services that are provided in a facility approved (licensed or accredited) by the State that is not a private residence.
4. Thirty units (days) of 24-hour respite per individual in a period of one fiscal year except when extended by the ODP Regional Office. This requirement is applicable to In-Home Respite – 24 Hours; Respite – Unlicensed Out of Home, 24 Hours; Respite – Licensed Out of Home, 24 Hours; and Respite – Camp, 24 Hours.
5. 480 (15 minute) units of 15-minute respite per individual in a period of one fiscal year except when extended by the ODP Regional Office. This requirement is applicable to In-Home Respite – 15 Minutes; Respite – Unlicensed Out of Home, 15 Minutes; Respite – Licensed Out of Home, 15 Minutes; and Respite – Camp, 15 minutes.

The provision of respite services does not prohibit supporting individuals' participation in activities in the community during the period of respite. The provision of 24-hour respite services does not prohibit individuals' participation in day and employment services.

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

- Individual's home or place of residence located in Pennsylvania.
- Licensed or approved foster family home located in Pennsylvania.
- Licensed community (55 Pa. Code Chapter 6400) or family living (55 Pa. Code Chapter 6500) home located in Pennsylvania with an approved program capacity of ten or fewer unrelated individuals if established prior to January 1, 1996 and with an approved program capacity of four or fewer unrelated individuals if established on or after January 1, 1996. The size limitations may be waived by ODP based on individual circumstances and needs.
- Unlicensed home of a provider or individual meeting the qualifications.
- Other community settings such as summer camp where the setting meets applicable state or local codes and the provider of service meets the provider qualifications established by the Department.

This service is not available for people residing in agency-owned, rented/leased, or operated (i.e. licensed and unlicensed Family Living homes) homes.

Respite billed under the following codes can only be funded through waiver dollars. These services may **not** be provided in Nursing Homes, Hospitals, or ICFs/MR. Respite may be provided in hospitals and nursing homes through base funding under Base-Funded Respite Care.

The code and service units for In-Home Respite – 24 Hours follow:

This service is provided in segments of day units. This service is provided in the private homes of individuals with mental retardation.

W7247		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	Day
W7248		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	Day
W7250		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	Day
W7251		Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.	Day
W7252		Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	Day
W7253		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.	Day

The code and service units for In-Home Respite – 15 Minutes follow:

This service is provided in segments of 16 hours or less in individuals' private homes. There is no requirement for the regular caregiver to be absent from the setting in which respite is provided.

W7255		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	15 minutes
W7256		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	15 minutes
W7258		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7264		Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.	15 minutes
W7265		Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7266		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.	15 minutes

Respite – Unlicensed Out of Home, 24 Hours

This service is provided in segments of day units. This service is provided in the private homes of family or friends with whom the individual does not reside, or other unlicensed homes or locations acceptable to individuals/families and subject to provider qualification criteria.

W8000		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	Day
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W8001		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	Day
W8002		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	Day
W8003		Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.	Day
W8004		Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	Day
W8005		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.	Day

Respite – Unlicensed Out of Home, 15 Minutes

This service is provided in segments of 16 hours or less. This service is provided in the private homes of family or friends with whom the individual does not reside, or other unlicensed homes or locations acceptable to individuals/families and subject to provider qualification criteria.

W8010		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	15 minutes
W8011		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	15 minutes
W8012		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W8013		Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.	15 minutes
W8014		Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W8015		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.	15 minutes

Respite – Licensed Out of Home, 24 Hours

This service is provided in segments of day units in licensed residential homes under 55 Pa. Code Chapter 3800, 5310, 6400 and 6500.

The code and service units for Licensed Out of Home Respite – 24 Hours follow:

W7259		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	Day
W7260		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	Day
W7262		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	Day

W7263		Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.	Day
W7299		Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	Day
W7300		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.	Day
	U2	Respite – Permanent Vacancy	Respite is being provided in a home with a permanent vacancy.	Day

Respite – Licensed Out of Home, 15 minutes

This service is provided in segments of 16 hours or less in licensed (3800, 5310, 6400, 6500) residential homes.

The code and service units for Licensed Out of Home Respite – 15 minutes follow:

W7267		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	15 minutes
W7268		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	15 minutes
W7270		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7400		Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.	15 minutes
W7401		Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7402		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.	15 minutes

Respite – Camp, 24 hours

24-hour Camp respite services are provided in segments of day units in overnight camp settings. Overnight camps are community settings that offer overnight group accommodations and organized supervision, socialization, skill-building, and/or instruction activities.

The code and service units for Respite – Camp, 24 hours follow:

W7285		Respite – Camp, 24 hours, Eligible	The eligible portion of the service provided in segments of day units in residential camp settings. Respite in overnight camps is not contingent upon an emergency situation.	Day
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Respite – Camp, 15 minutes

15-minute camp services are provided in segments of 16 hours or less in day camp settings. Day camps are community settings that offer group accommodations and organized supervision, socialization, skill-building, and/or instruction activities.

The code and service units for Respite – Camp, 15 minutes follow:

W7286		Respite – Camp, 15 minutes, Eligible	This service is provided in segments of 16 hours or less in day camp settings. Respite in day camps is not contingent upon an emergency situation.	15 minutes
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Respite – Ineligible (Room and Board) Costs

Room and board costs are excluded from respite services when the service is provided in a setting that is not licensed or accredited by the State. If there are room and board costs for these settings, they may be funded through the ineligible codes listed below.

The code and service units for Respite – Ineligible Costs follow:

W8400		Respite – Ineligible Costs, 15 minutes	This code is used for the ineligible (room and board) portion of respite services that are provided in settings that are not licensed or accredited by the State.	15 minutes
W8401		Respite – Ineligible Costs, 24 hours	This code is used for the ineligible (room and board) portion of respite services that are provided in settings that are not licensed or accredited by the State.	Day

Transportation Service

Direct services to provide transportation to enable individuals to access services and activities in accordance with their approved ISP.

This includes transportation that is provided by Adult Training Facilities, Prevocational Service and Transitional Work Service providers who transport individuals to and from their homes and provider sites. It is **not** transportation that is an integral part of the provision of activities within Habilitation Service settings nor is it transportation associated with Residential Habilitation Services, as transportation in these situations is built into the rate for the habilitation service.

Transportation (Mile)

This transportation service is provided by family, friends, and other licensed drivers for using non-agency vehicles to transport the individual to services and activities specified in the individual's ISP. The unit of service is one mile. The rate for this service is the current state rate for mileage reimbursement effective the January 1st immediately preceding the beginning of the impacted fiscal year.

When transportation is provided to more than one individual at a time, the total number of units of service that are to be provided are equitably divided among the individuals for whom transportation is provided.

The code and service units for Transportation (Mile) follow:

W7271		Transportation (Mile)	Transportation by providers, family members, and other licensed drivers for using vehicles to transport the individual to services or activities specified in the individual's approved individual support plan. When transportation is provided to more than one individual at a time, the total number of units of service provided is equitably divided among the people for whom transportation is being provided. Mileage reimbursement to providers is limited to situations where transportation costs are not included in the provider's rate for other services.	Per mile
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Public Transportation

Public transportation services are provided to individuals to enable them to gain access to services and resources specified in their ISPs. The utilization of public transportation promotes self-determination and is made available to individuals as a cost-effective means of accessing services and activities.

Public transportation tokens and transit passes may be purchased by the AE, AE contracted payment agents, Financial Management Service Organizations, or providers of service.

Tokens/passes that are purchased for an individual may be provided to the individual on a daily, weekly or monthly basis.

The code and service units for Public Transportation follow:

W7272		Public Transportation	Public transportation costs to enable individuals with mental retardation in accessing services and activities specified in the individual's approved individual support plan.	Outcome based
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Transportation – Per Diem

This is transportation provided to an individual by provider agencies for non-emergency purposes. The service is designed to provide individuals with access to services and activities specified in their ISP.

The code and service units for Transportation – Per Diem follow:

W7273		Transportation (per diem)	Non-emergency transportation provided to individuals with mental retardation by provider agencies, in order to enable individuals to access services and activities specified in the individual's approved individual support plan. These costs are prorated by the usage for individuals receiving waiver services when vehicles are also used for accessing services and activities for people who are not waiver participants.	Day
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Transportation – Trip

Transportation provided to individuals (excluding transportation included in the rate for habilitation services) for which costs are determined on a per trip basis. A trip is either transportation to a service/activity from an individual's home or from the service/activity to the individual's home. Taking an individual to a service/activity and returning the individual to his/her home is considered two trips or two units of service.

The code and service units for Transportation – Trip follow:

W7274		Zone 1	A defined geographical area that is the shortest distance from the service site.	Per trip
W7275		Zone 2	A defined geographical area that represents a middle distance from the service site.	Per trip
W7276		Zone 3	A defined geographical area that is the longest distance from the service site.	Per trip

Home Finding Services

Direct services provided to assist individuals to locate and maintain their own home. Services are limited to assistance in financial planning, arranging for or moving utility hook-ups, managing home responsibilities, arranging for home modifications and repairs, making monthly payments, and assistance in purchasing home security devices, such as beepers which are necessary to ensure the individual's health and well-being.

Financial support that constitutes a room and board expense is excluded from federal financial participation in the waivers.

The code and service units for Home Finding follow:

W7277		Home Finding	Direct services provided to assist a individual with mental retardation to locate and maintain a home, such as assistance in financial planning, arranging for or moving utility hook-ups, managing home responsibilities, arranging for home modifications and repairs, making monthly payments, and assistance in purchasing home security devices such as beepers which are necessary to ensure the individual's health and well-being.	15 minutes
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Home Accessibility Adaptations

Home accessibility adaptations consist of certain modifications to the private home of the individual (including homes owned or leased by parents/relatives with which the individual resides) which are necessary due to the individual's disability, to ensure the health, security, and accessibility of the individual, or which enable the individual to function with greater independence in the home. This service may only be used to adapt the individual's primary residence, may not be furnished to adapt homes that are owned or leased by providers.

Home modifications must have utility primarily for the individual with the disability, be an item of modification that the family would not be expected to provide to a family member without a disability, be an item that is not part of general maintenance of the home, and be an item or modification that is not part of room and board costs as defined in 55 Pa.Code Chapter 6200. Home modifications consist of installation, repair, maintenance, and extended warranties for the modifications; and when necessary to comply with rental/lease agreements, return of the property to its original condition. Adaptations that add to the total square footage of the home are excluded from this benefit. The only exception to this is adaptations to bathrooms that are necessary to complete the adaptation (e.g., necessary to configure a bathroom to accommodate a wheelchair). Durable medical equipment is excluded.

All modifications shall meet the applicable standards of manufacture, design, and installation. Modifications shall be specific to the individual's needs and not be approved to benefit the public at large, staff, significant others, or family members; modifications or improvements to the home that are of general utility are excluded. Modifications not of direct medical or remedial benefit to the individual are excluded.

Maximum state and federal funding participation is limited to \$20,000 per individual during a 10-year period. The 10-year period begins with the first utilization of authorized Home Accessibility Adaptations. A new \$20,000 limit can be applied when the individual moves to a new home. The 10 year period begins at the first utilization of authorized Home Accessibility Adaptations. For tracking purposes, the date, nature, and cost of the most recent Home Accessibility Adaptation should be documented in the ISP in the 'Physical Development' field. In situations of joint custody (as determined by an official court order) or other situations where an individual divides their time between official residences, the adaptations must be allowable services and must be completed within the overall monetary limit of \$20,000 for this service.

Modifications to a household subject to funding under the waivers are limited to the following:

- Ramps from street, sidewalk or house.
- Vertical lifts.
- Portable or track lift systems. A portable lift system is a standing structure that can be wheeled around. A track lift system involves the installation of a "track" in the ceiling for moving an individual with a disability from one location to another.
- Handrails and grab-bars in and around the home.
- Accessible alerting systems for smoke/fire/CO2 for individuals with sensory impairments.
- Electronic systems that enable someone with limited mobility to control various appliances, lights, telephone, doors, and security systems in their room, home or other surroundings
- Outside railing from street to home.
- Widened doorways, landings, and hallways.
- An additional doorway needed to ensure the safe egress of the individual during emergencies, when approved by the ODP Regional Office.
- Swing clear and expandable offset door hinges.
- Flush entries and leveled thresholds.
- Plexiglas windows for individuals with behavioral issues as noted in the individual's ISP.
- Slip resistant flooring.
- Kitchen counter, major appliance, sink and other cabinet modifications.
- Bathroom modifications for bathing, showering, toileting and personal care needs.

- Bedroom modifications of bed, wardrobe, desks, shelving, and dressers.
- Stair gliders and stair lifts. A stair lift is a chair or platform that travels on a rail, installed to follow the slope and direction of a staircase, which allows a user to ride up and down stairs safely.
- Workroom modifications to desks and other working areas.

All adaptations to the household shall be provided in accordance with applicable building codes.

The code and service units for Home Accessibility Adaptations follow:

W7279		Home Accessibility Adaptations	Adaptations to homes for improved access and/or safety for individuals with mental retardation. Maximum state participation for home adaptations is limited to \$20,000 per individual for a 10-year period. A new \$20,000 limit can be applied when the individual moves to a new home.	Outcome based
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Vehicle Accessibility Adaptations

Vehicle accessibility adaptations consist of certain modifications to the vehicle of the individual (including a vehicle owned by parents/relatives/legal guardians with which the individual resides) which are necessary due to the individual’s disability. Vehicle modifications consist of installation, repair, maintenance, and extended warranties *for the modifications*. Regularly scheduled upkeep and maintenance of the vehicle, including warranties that cover the entire vehicle, except for upkeep and maintenance of the modifications, is excluded.

The waivers cannot be used to purchase vehicles for waiver recipients, their families or legal guardians; however, this service can be used to fund the portion of a new or used vehicle purchase that relates to the cost of accessibility adaptations. In order to fund these types of adaptations, a clear breakdown of purchase price versus adaptation is required.

Maximum state and federal funding participation is limited to \$10,000 per individual during a 5-year period. The 5-year period begins with the first utilization of authorized Vehicle Accessibility Adaptations. For tracking purposes, the date, nature, and cost of the most recent Vehicle Accessibility Adaptation should be documented in the ISP in the ‘Physical Development’ field.

These adaptations funded through the waivers are limited to the following:

- Vehicular lifts.
- Interior alterations to seats, head and leg rests, and belts.

- Customized devices necessary for the individual to be transported safely in the community, including driver control devices.
- Raising the roof or lowering the floor to accommodate wheelchairs.

The code and service units for Vehicle Accessibility Adaptations follow:

W7278		Vehicle Accessibility Adaptations	Adaptations to vehicles for improved access and/or safety for individuals with mental retardation. Maximum state participation for vehicle adaptations is limited to \$10,000 every 5 years.	Outcome based
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Assistive Technology

An item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve an individual's functioning.

Assistive technology services include direct support to an individual in the selection, acquisition, or use of an assistive technology device, limited to:

- Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the individual;
- Selecting, fitting, customizing, adapting, maintaining, repairing, or replacing assistive technology devices;
- Training for the individual, or, where appropriate, the individual's family members, guardian, advocate, staff, or authorized representative on how to use and/or care for the assistive technology;
- Extended warranties; and
- Ancillary supplies, software, and equipment necessary to the proper functioning of assistive technology devices, such as replacement batteries and materials necessary to adapt low-tech devices.

Please note that repair and maintenance of devices and purchases of extended warranties are limited to those devices purchased through the Waivers.

All items shall meet the applicable standards of manufacture, design, and installation. Items shall be specific to the individual's needs and not be approved to benefit the public at large, staff, significant others, or family members. Items reimbursed with waiver funds shall be in addition to any medical supplies provided under the Medicaid state plan and shall exclude those items not of direct medical or remedial benefit to the individual. If the participant receives Behavioral Therapy or Behavioral Support Services, the assistive technology must be consistent with the individual's behavioral support plan.

Assistive technology devices must be recommended by an independent evaluation of the individual's assistive technology needs. The organization or professional providing the evaluation shall be credentialed, licensed, or certified in an area related to the specific type of technology needed, and may not have a fiduciary relationship with the assistive technology provider.

This service excludes durable medical equipment, as defined by Title 55 PA Code Chapter 1123 and the Medical Assistance State Plan.

Assistive Technology may only be funded through the waiver or base allocation when the service may not be provided under the State Plan or private insurance because the State Plan or insurance limitations have been reached, or when the service is not covered under the State Plan or private insurance. The Supports Coordinator is responsible to verify that the State Plan and/or private insurance limitations have been exhausted prior to funding Assistive Technology services through the Consolidated or P/FDS Waiver. Documentation that the services are not available through the State Plan and/or private insurance must be maintained in the individual's file by the Supports Coordinator. This documentation must be updated on at least an annual basis. The documentation requirement can be met by including detailed information in the person's hard copy file and/or a service note in HCSIS. In addition, a summary of the documentation should be included in the 'Outcome Summary' page of the HCSIS ISP (in the 'Concerns Related to Outcome' field) page of the HCSIS ISP, as the information is needed for authorization. The individual and/or their family and the Supports Coordination must collaborate to obtain documentation to meet this requirement. Examples of acceptable documentation include: summary of a telephone conversation with the individual's insurance provider, excerpts from benefit statements showing that the service is not available, evidence that the individual is no longer eligible for benefits, etc.

The code and service units for Assistive Technology follow:

T2028 (For non-medical Assistive Technology)	SE	Assistive Technology	The purchase or modification of assistive technology for increased functional involvement of individuals with mental retardation in their activities of daily living.	Outcome based
T2029 (For medical Assistive Technology)	SE			

Homemaker/Chore Services

Homemaker services consist of services to enable the individual or the family with whom the individual resides to maintain their private residence. This service can only be provided when a household member is temporarily absent or unable to manage the home, or when no landlord or provider agency staff is responsible to perform the homemaker activities. Homemaker Services must be provided by a qualified homemaker and may include cleaning and laundry, meal preparation, and other general household care.

Chore services consist of services needed to maintain the home in a clean, sanitary, and safe condition. This service can only be provided in the following situations:

- Neither the individual, nor anyone else in the household, is capable of performing and financially providing for the function; and
- No other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision.

Chore services consist of heavy household activities such as washing floors, windows, and walls; tacking down loose rugs and tiles; moving heavy items of furniture in order to provide safe access and egress; ice, snow, and/or leaf removal; and yard maintenance. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Maintenance in the form of upkeep and improvements to the individual's residence is excluded from federal financial participation.

This service is limited to 40 hours per individual per fiscal year when the individual and everyone else in the household are temporarily unable to perform and financially provide for the homemaker/chore functions. A person is considered temporarily unable when the condition or situation that prevents them from performing and financially providing for the homemaker/chore functions is expected to improve. There is no limit when the individual lives independently or with family member(s) or friend(s) who are permanently unable to perform and financially provide for the homemaker/chore functions. A person is considered permanently unable when the condition or situation that prevents them from performing and financially providing for the homemaker/chore functions is not expected to improve. The ISP team is responsible to determine whether a person is temporarily or permanently unable to perform and financially provide for the homemaker/chore functions. The ISP team's determination should be documented in the 'Outcome Summary' section of the ISP.

This service is not available for people residing in agency-owned, rented/leased, or operated (i.e. licensed and unlicensed Family Living homes) homes.

The code and service units for Homemaker/Chore follow:

W7283	<p>UA modifier when the caregiver is temporarily unable to perform and financially provide for the functions (limited to 40 hours per fiscal year)</p> <p>No modifier when the individual lives independently or the caregiver is permanently unable to perform and financially provide for the functions</p>	Homemaker/Chore	<p>Indirect services including household cleaning and maintenance and homemaker activities. This service may only be provided when the individual, or anyone else in the household, is incapable of performing and financially providing for the function; and no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision.</p>	Hour
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Education Support Services

Education support services consist of special education and related services as defined in Sections (15) and (17) of IDEA to the extent that they are not available under a program funded by IDEA or available for funding by OVR. Educational support services may consist of general adult educational services including community college, university or other college-level courses, classes, tutoring to receive a General Educational Development (GED) degree, and assistance necessary for the person to participate in apprenticeship programs.

The code and service units for Education Support Services follow:

W7284		Education Support Services	<p>Support, in the form of payment, for education courses and training to the extent that they are not available under a program funded by IDEA.</p>	Outcome based
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Specialized Supplies

Specialized Supplies consist of incontinence supplies that are not available through the State Plan or private insurance. Supplies are limited to adult diapers, incontinence pads, cleansing wipes, underpads, and vinyl or latex gloves. This service is limited to \$500 per individual per fiscal year.

Specialized Supplies may only be funded through the waiver or base allocation when the service may not be provided under the State Plan or private insurance because the State Plan or private insurance limitations have been reached, or when the service is not covered under the State Plan or private insurance. The Supports Coordinator is responsible to verify that the State Plan and/or private insurance limitations have been exhausted prior to funding Specialized Supplies through the Consolidated or P/FDS Waiver. Documentation that the services are not available through the State Plan and/or private insurance must be maintained in the individual's file by the Supports Coordinator. This documentation must be updated on at least an annual basis. The documentation requirement can be met by including detailed information in the person's hard copy file and/or a service note in HCSIS. In addition, a summary of the documentation should be included in the 'Outcome Summary' page of the HCSIS ISP (in the 'Concerns Related to Outcome' field) page of the HCSIS ISP, as the information is needed for authorization. The individual and/or their family and the Supports Coordination must work together regarding this requirement. Examples of acceptable documentation include: summary of a telephone conversation with the individual's insurance provider supported by a copy of the coverage policy; excerpts from benefit statements showing that the service is not available; evidence that the individual is no longer eligible for benefits, such as a termination of coverage letter; etc.

The code and service units for Specialized Supplies follow:

W6089		Specialized Supplies	Incontinence supplies not available through the State Plan or private insurance, limited to adult diapers, incontinence pads, cleansing wipes, underpads, and vinyl or latex gloves. This service is limited to \$500 per individual per fiscal year.	Outcome based
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Administrative Services

Financial Management Services (previously referred to as Intermediary Service Organizations)

Payment for FMS must be made using administrative dollars, not waiver service dollars.

FMS organizations provide an indirect service that must meet contractual conditions and federal and state requirements. The service assists individuals and surrogates in the employment and management of support service workers and vendors.

Vendor Fiscal/Employer Agent FMS

Under the Vendor Fiscal/Employer Agent FMS model, the individual or their surrogate is the “Employer of Record” by IRS standards. The FMS is paid a monthly administrative fee to function as an employer agent on behalf of the individual or their surrogate, who function as the common law employer, for the purpose of withholding, filing and paying federal employment taxes and income taxes, as required for an individual’s qualified support services workers.

The code and service units for Vendor Fiscal/Employer Agent FMS follow:

W7318		Vendor Fiscal/Employer Agent Financial Management Services	An indirect service that assists individuals with mental retardation and/or their surrogates in the direct employment and management of qualified support service workers and vendors of their choice. This service may only be provided by the Vendor Fiscal/Employer Agent on contract with ODP after January 1, 2009.	Per month
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Agency with Choice FMS

Under the Agency with Choice FMS model, the FMS organization is the “Employer of Record” by IRS standards and receives a monthly administrative fee to function as the co-employer with the individual or their surrogate. Under this model the FMS organization and the individual or their surrogate work together to perform many employer-related functions such as hiring workers, developing worker schedules, managing day-to-day responsibilities of workers, providing orientation and training to workers, and disciplining and firing workers when necessary. The FMS organization is responsible for invoicing for services rendered, processing employment documents, paying workers, and providing worker compensation for workers.

The code and service units for Agency with Choice FMS follow:

W7319		Agency with Choice Financial Management Services	An indirect service that assists individuals with mental retardation and/or their surrogates in the employment and management of qualified support service workers and vendors of their choice.	Per month
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Base/Waiver Ineligible Services

The services included in the remainder of this narrative are designated as Base-Funded, and are limited to non-waiver (ineligible) funding only.

Base/Waiver Ineligible Services are provided through non-waiver funding, and are available to all individuals with mental retardation in need of services. Base Services are administered through County Programs, based on the needs of individuals and the availability of funding. These services are designed to offer a variety of services to the individual with mental retardation or their family for the purpose of enabling the individual to remain with his/her family in a community setting or to maintain independence in a community setting.

Base-Funded Respite Care

These respite services may be provided through base funding.

Respite Services are direct services that are provided to supervise/support individuals on a short-term basis due to the absence or need for relief of those persons normally providing care. Respite Services do not cover the care provided to a minor child when the primary caregiver or legally responsible individual is absent due to work. Services are limited to individuals residing in private homes (their own home or the home of a relative or friend). Respite Services must be required to meet the current needs of the individual, and the needed services and supports must be documented and authorized in ISPs.

Individuals can receive two categories of respite services: 24-hour respite and 15-minute respite. 24-hour respite is provided for periods of more than 16 hours. 15-minute respite is provided in segments of time of 16 hours or less. Base-Funded Respite Care is limited to a **total** (including 24-hour and 15-minute respite) of 4 weeks (28 days) per individual per fiscal year, except when extended by an ODP Regional Office waiver.

The provision of respite services does not prohibit supporting individuals' participation in activities in the community during the period of respite.

Base-Funded Respite may be provided in the following locations:

1. Individual's home or place of residence located in Pennsylvania.
2. Licensed or approved foster family home located in Pennsylvania.
3. Licensed community (55 Pa. Code Chapter 6400) or family living (55 Pa. Code Chapter 6500) home located in Pennsylvania.
4. Unlicensed home of a provider or family that the County Program has approved.
5. Medical facilities, such as hospitals, nursing homes, or private Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) when

there is a documented medical need and County Administrator approves the habilitation in a medical facility. **Respite services may not be provided in state-operated ICFs/MR.**

Base-Funded Respite Care – Out of Home, 24 Hours

The following codes are for direct services that are provided in segments of day units to individuals residing in their own home or the home of a relative, friend, or other family.

The code and service units for Base-Funded Out of Home Respite Care – 24 Hours follow:

W7287		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	Day
W7288		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	Day
W7290		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	Day
W7099		Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.	Day
W7100		Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	Day
W7101		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.	Day

Base-Funded Respite Care – Out of Home, 15 minutes

Out of Home respite care are direct services that are provided in segments of 16 hours or less to individuals residing in their own home or the home of a relative, friend or other family.

The code and service units for Base-Funded Out of Home Respite Care – 15 Minutes follow:

W7301		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	15 minutes
W7302		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	15 minutes
W7304		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7222		Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.	15 minutes
W7223		Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7224		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.	15 minutes

Support (Medical Environment)

This service may be used to provide support in general hospital or nursing home settings, when there is a documented need and the County Program Administrator or Director approves the support in a medical facility. The service is intended to supply the additional support that the hospital or nursing home is unable to provide due to the individual's unique behavioral or physical needs. This service is available using base (non-waiver) funds to Waiver participants and to individuals receiving base-funded services, including both individuals living at home and those residing in provider-operated settings. Base/Waiver Ineligible Services are provided through non-waiver funding, and are available to all individuals with mental retardation in need of services.

The code and service units for Support (Medical Environment) follow:

W7305		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes
W7306		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7307		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7309		Level 3	The provision of the service at a staff-to-individual ratio range of 1:1.	15 minutes
W7321		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.	15 minutes
W7322		Level 4	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7323		Level 4 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.	15 minutes

Base-Funded Licensed Residential Services

The following services and codes may be used for Licensed Residential Services that are funded through Base funds due to the size of the home (serving 11 or more individuals):

Child Residential Services (The residential section of 55 Pa. Code Chapter 3800, Child Residential and Day Treatment Facilities)

The 55 Pa. Code Chapter 3800 services that may be funded through the Consolidated Waiver are limited to residential service settings. Child residential services provided in secure settings, detention centers, and residential treatment facilities accredited by JCAHO may not be funded through the Consolidated Waiver.

The code and service units for Child Residential Services follow:

W7098		Ineligible	Child residential services that are not eligible for Consolidated Waiver funding due to the size of the home (serve 11 or more individuals).	Day
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Community Residential Rehabilitation Services for the Mentally III (CRRS), (55 Pa. Code Chapter 5310)

CRRS are characterized as transitional residential programs in community settings for people with chronic psychiatric disabilities. This service is full-care CRRS for adults with mental retardation and mental illness. Full-care CRRS for adults is a program that provides living accommodations for people who are psychiatrically disabled and display severe community adjustment problems. A full range of personal assistance and psychological rehabilitation is provided for individuals in a structured living environment. **Host homes are excluded.**

The code and service units for Community Residential Rehabilitation Services for the Mentally III follow:

W7203		Ineligible	Community residential rehabilitation services that are not eligible for Consolidated Waiver funding due to the size of the home (serve 11 or more individuals).	Day
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Community Homes for Individuals with Mental Retardation (55 Pa. Code Chapter 6400)

A licensed community home is a home licensed under 55 Pa. Code Chapter 6400 where services are provided to people with mental retardation. A community home is defined in regulations as, “A building or separate dwelling unit in which residential care is provided to one or more individuals with mental retardation....”

The code and service units for Community Homes for Individuals with Mental Retardation follow:

W7221		Ineligible	Community residential services that are not eligible for Consolidated Waiver funding due to the size of the home (serve 11 or more individuals).	Day
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Family Aide

Family aide services are direct services provided in segments of less than 24 hours to supervise/support individuals on a short-term basis due to the absence or need for relief of those persons normally providing care. The family aide may also be responsible for the care and supervision of family members other than the family member with mental retardation.

This service is limited to a recommended maximum of four sessions per month (one session is equal to a period of time less than 24 hours), but may be adjusted by the County Program based on individual needs.

The code and service units for Family Aide follow:

W7310		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes
W7311		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7312		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7314		Level 3	The provision of the service at a staff-to-individual ratio range of 1:1.	15 minutes
W7324		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is licensed or degreed.	15 minutes
W7325		Level 4	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7326		Level 4 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are licensed or degreed.	15 minutes

Special Diet Preparation

This service provides individuals with assistance in the planning or preparation of meals when needed due to a significant modification to a routine diet.

The code and service units for Special Diet Preparation follow:

W7315		Special Diet Preparation	This service provides individuals with mental retardation with assistance in the planning or preparation of meals when needed due to a significant modification to a routine diet.	Outcome based
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Recreation/Leisure Time Activities

This service is provided to enable individuals to participate in regular community activities that are recreational or leisure in nature. Participation in activities with non-related people, within the community, is encouraged. Entrance and membership fees may be included in the cost of recreation/leisure time activities. This service is available to Waiver participants and to individuals receiving base-funded services, including both individuals living at home and those residing in provider-operated settings.

The code and service units for Recreation/Leisure Time Activities follow:

W7316		Recreation/ Leisure Time Activities	This service is provided to enable individuals with mental retardation to participate in regular community activities that are recreational or leisure in nature.	Outcome based
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Home Rehabilitation

The home rehabilitation service provides for minor renovations to an individual's or family's home to enable the continued care and support of the individual in the home. A renovation is defined for reimbursement purposes as minor if the cost is \$10,000 or less, as per 55 Pa Code Chapter 4300.65(1). This service is available to Waiver participants and to individuals receiving base-funded services, including both individuals living at home and those residing in provider-operated settings.

The code and service units for Home Rehabilitation follow:

W7317		Home Rehabilitation	This service provides for minor renovations to an individual's or family's home to enable the continued care and support of the individual with mental retardation in the home.	Outcome based
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FSS/Individual Payment

FSS/Individual Payment provides an indirect service to assist individuals in the employment and management of individual providers of the non-waiver service of their choice.

The code and service units for FSS/Individual Payment follow:

W7320		FSS/Individual Payment	This is an indirect service to allow cash and/or voucher payments to individuals and families for Family Supports Services.	Dollar
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Base Service Not Otherwise Specified

This service is provided through base funds and is designed to meet the unique needs of the individual receiving services and/or their family. Services must be required to meet the current needs of the individual, as documented and authorized in the ISP

The code and service units for Base Service Not Otherwise Specified follow:

W7219	Base Service Not Otherwise Specified	This service is provided through base funds and is designed to meet the unique needs of the individual receiving services and/or their family.	Outcome-based
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ⁱ The travel policy applies to the following services: Unlicensed Home and Community Habilitation, Residential Habilitation (licensed and unlicensed), Respite, Nursing, Therapy, Supports Coordination, Supports Broker, Behavioral Support, Companion, Specialized Supplies, and Transportation.

ⁱⁱ Therapeutic activities are those activities designed to help a person acquire, maintain, or improve a skill necessary to live successfully in the home and community.

ⁱⁱⁱ The only exception is when Unlicensed Home and Community Habilitation is utilized as a non-traditional day service for individuals in Licensed Residential settings.

^{iv} The 15 minute unit comprises of 15 minutes of continuous or non-continuous service *within the same calendar day*. The full 15 minutes of service must be rendered in the day in order for a unit of service to be billed. This applies to all services that use a 15 minute unit.

^v Staff providing enhanced habilitation must meet the following: Licensed Nurse or a professional with a Degree (at least 4 year).

^{vi} A day is defined as a period of a minimum of 12 hours of non-continuous care rendered by a residential habilitation provider within a 24 hour period beginning at 12:00 a.m. and ending at 11:59 p.m. The care may be provided in non-consecutive hours and may be rendered in the residential site, in the community, or while traveling, consistent with ODP's travel policy. This definition of a day unit is to be used for planning and billing purposes even if the provider uses a different timeframe to define a unit.

^{vii} For planned moves, the provider of the current residential habilitation site is responsible to initiate the process to fill the vacancy immediately upon notification or recognition of an impending vacancy. For example, an individual who resides in a residential site operated by Provider A notifies the provider of their intent to move to a residential site operated by Provider B. Upon notification of the intent to move, the transition process begins, and Provider A is responsible to notify the authorizing AE to begin the vacancy management process. In these situations, the vacancy management process will take place during the transition of the individual from Provider A to Provider B.

^{viii} Not everyone can make legally binding decisions for themselves. This would include minor children and some adults who have substantial mental impairment. In these instances, a substitute decision-maker may be identified under State law. Substitute decision-makers have

various legal titles, but for the purposes of this bulletin, they will be referred to as “surrogates.” “Surrogates” include the following:

- Parents of children under 18 years of age under the common law and 35 P.S. § 10101.
- Legal custodian of a minor as provided in 42 Pa.C.S. § 6357.
- Health care agents and representatives for adults as provided in 20 Pa.C.S. Ch. 54.
- Guardians of various kinds as provided in 20 Pa.C.S. Ch. 55 (as limited by 20 Pa.C.S. § 5521(f)).
- Holders of powers of attorney of various kinds as provided in 20 Pa.C.S. Ch. 56.
- Guardians of persons by operation of law in 50 P.S. §4417(c).

Any of these would be considered “legal representatives” as the Center for Medicaid and Medicare Services uses that phrase. Please see *Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria* [www.cms.hhs.gov/HCBS/02_QualityToolkit.asp].

^{ix} Services or organizations available within the individual's community.

^x Unpaid assistance to an individual.