Welcome to the Office of Developmental Programs Overview of Proposed Changes to the Consolidated and Person/Family Directed Support waivers. My name is Julie Mochon and I am the Director of ODP’s Policy Division. Joining me today is Kristin Ahrens, the Director of ODP’s Bureau of Policy and Quality Management. We will provide you with an overview of the proposed changes in the renewals to the waivers.

The Centers for Medicare and Medicaid Services or “CMS” approves the waivers for 5 year periods. The current Consolidated and P/FDS waivers expire on June 30, 2017. While ODP can and often has amended the waivers during the 5 year period, the renewals are a time to look at what is working and what can be improved. The renewals are a time to plan and implement larger changes.

In the past ODP has provided side-by-sides to highlight changes. With these renewals, the changes were so significant that we were unable to provide a side-by-side. Instead, we conducted “Preview” web sessions in October. A recorded version of the “Preview” is available on the MyODP website. We have provided a link to the preview on the last slide.

Waiver applications to CMS consist of Appendices A through J. ODP published the proposals for appendices A through H which cover things like program administration, eligibility, and services. ODP will publish the proposed appendices I and J in January. I and J cover the rates and financial aspects of the waivers. In this webcast we will describe the major changes in each of the appendices A through H.
Appendix A – Waiver Administration and Operation

Appendix A identifies the state agency that is responsible for the day-to-day waiver administration and operation, other contracted entities that perform waiver operational functions, and, if applicable, local and regional entities that have waiver administrative responsibilities. The Office of Developmental Programs or ODP is responsible for the administration of the Consolidated and P/FDS Waivers, including the development and distribution of waiver related policies, rules, and regulations.

ODP has an agreement with County Mental Health/Intellectual Disability or MH/ID programs, which are referred to as Administrative Entities, to perform delegated waiver and operational administrative functions discussed in Appendix A.
There have been no major changes in the waiver administrative functions delegated to Administrative Entities. As a result there are few changes to discuss in Appendix A.

There are some important terminology changes that you will see throughout the waivers that are first introduced in Appendix A. You will see that the Individual Service Plan or ISP is now referred to in the waivers as the service plan. You will also see that the Prioritization of Urgency of Need for Services or PUNS is now referred to as the waiting list assessment of need. While we don’t anticipate major changes to these documents in the next year, we hope to make changes to these documents in the following years.

ODP currently assesses the performance of Administrative Entities every year. ODP is streamlining the monitoring processes for Administrative Entities and waiver providers, including Supports Coordination Organizations. As a result, monitoring for all of these entities will be done on a 3-year cycle.
This slide and the next are charts that you will find in Appendix A that explain who is responsible for different waiver administrative functions. The first column is ODP. The second column is for Administrative Entities or AEs. As previously noted, there are no major changes for these responsibilities.
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<th>Function</th>
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<td>Utilization management</td>
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<td>Qualified provider enrollment</td>
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<td>Establishment of a statewide rate methodology</td>
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<td>Rules, policies, procedures, and information development</td>
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<td>Quality assurance and quality improvement activities</td>
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Appendix B – Participant Access and Eligibility

Appendix B, Participant Access and Eligibility, is designed to answer the question: “Who receives services?”
In Appendix B-1 the “Target groups” are listed. Target Group is a CMS term that refers to a specific group or groups of individuals who meet an institutional level of care which a state determines that it wants to serve in the waiver. The Consolidated and the P/FDS waivers currently serve individuals with a diagnosis of intellectual disability. We propose to expand eligibility in these two waivers to add individuals who are diagnosed with autism. We also propose to add individuals who are age 0 or birth to 7 who are diagnosed with a developmental disability. We will discuss the eligibility criteria for these two groups in a couple of slides.

It is important to note that these proposed changes do not impact the Adult AutismWaiver or ACAP which will continue to be operated by ODP’s Bureau of Autism Services.
In Appendix B-1, Maximum Age under B-1-c, since we’re proposing to serve individuals with a developmental disability from birth to age 7, this section explains that individuals will have to be reevaluated prior to their 8th birthday. The evaluation will determine if they meet the level of care eligibility criteria for an intellectual disability or autism to continue to receive services on the day they turn 8. If the individual is not eligible, he or she will be referred to other resources such as Medicaid, the Office of Long Term Living, the Office of Children, Youth and Families as applicable and the Office of Mental Health and Substance Abuse Services.
In B-6-d, which is the ICF/ID Level of Care, there is no change to the criteria for intellectual disability. We’re going to present the information a little out of order here because the information in Appendix B-6-d ties in nicely with the target group information that we just discussed. So in this section of the waiver we discuss the proposed level of care criteria for waiver eligibility. The eligibility criteria that you see on this slide are the criteria that must be met for a person to be determined to have an intellectual disability with an ICF/ID level of care—so that’s Intermediate Care Facility for Intellectual Disability (ICF/ID) Level of Care—in order to initially receive the Consolidated or P/FDS Waiver services.

There are four eligibility criteria:

- The person must have a diagnosis of an intellectual disability.
- The intellectual disability must have occurred prior to age 22.
- The person must have adaptive skills deficits in 3 or more areas of major life activity.
- The person must also be recommended for an ICF/ID level of care based on a medical evaluation.
So in the B-6-d ICF/ORC Level of Care, this is related to Autism; ICF/ORC is Intermediate Care Facility for Other Related Conditions. The eligibility criteria that you see on this slide are criteria that must be met for a person to be determined to have autism with the ICF/ORC level of care in order to initially receive the Consolidated or P/FDS Waiver services.

So here there are four criteria:

- The person must have a diagnosis of autism.
- Autism must have occurred prior to age 22.
- The person must have substantial adaptive skills deficits in three or more areas of major life activity.
- And the person must be recommended for an ICF/ORC level of care based on a medical evaluation.
Again we've added in B-6-d because we've added developmental disability for individuals birth to seven. The ICF/ORC criteria are added here as well, the four criteria are:

• The person must have a diagnosis of a developmental disability
• The person must be 7 years old or younger
• The person must have substantial adaptive skills deficits in three or more areas of major life activity and
• The person must be recommended for an ICF/ORC level of care based on a medical evaluation.
So going backwards here, now that we have talked about eligibility, let’s talk about the unduplicated number of participants served by each waiver. The waiver applications require that ODP indicates the maximum number of people it will serve in each waiver. It is important to note that annual adjustments may be made based upon the adoption of the Commonwealth budget. You’ll see on the slide here the Consolidated waiver, years one through five, has the unduplicated number of participates to be served is 18,097 people; for the P/FDS the number is 13,900.
This slide and the next slide both capture what’s called the reserved capacity or capacity that is set aside in each waiver for specific groups. Again, like the numbers you saw in the last slide, annual adjustments may be made to these numbers based upon adoption of Commonwealth budget.

So on this slide, this is relating to the Consolidated Waiver. We have categories reserved for:

- Unanticipated Emergencies and Hospital/Rehabilitation care. There are no changes here.
- Reserved capacity for litigation is for individuals identified to move from state operated ICF/ID and who have been identified for enrollment through litigation. In addition, ODP will reserve capacity for individuals served by private ICF/ID providers that have agreed to convert a setting to a waiver funded setting or to reduce bed capacity to meet waiver standards. ODP will reserve capacity for individuals residing in a Skilled Nursing Facility or a Psychiatric Residential Treatment Facility who are transitioning to the community.
- Reserved capacity for Age Out and Transitions that you see on the slide is new. Administrative Entities will work in conjunction with Supports Coordination Organizations to anticipate and prioritize the needs of participants who are expected to require waiver services within the year due to:
  - Aging out of the Office of Children, Youth and Family Services; or
  - Aging out of services received through Early and Periodic Screening Diagnostic and Treatment (EPSDT) that’s a Medical Assistance program;
  - Discharge from a Residential Treatment Facility or an RTF;
  - Release from prison;
  - Or discharge from a state hospital.

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<th>Age Out and Transitions – NEW</th>
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<th>Unanticipated Emergencies – No Change</th>
<th>Hospital/Rehabilitation Care</th>
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<td>Year 1 – 80</td>
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ODP allows Administrative Entities to reserve existing capacity for participants who require future services due to the different criteria that I’ve just listed. Capacity can be reserved up to 120 days prior to the expected need for services for that person. This allows the AEs and Supports Coordination Organizations to plan accordingly prior to the transition and possibly a crisis or emergency situation.
This slide is the reserved waiver capacity for the P/FDS waiver. Again, annual adjustments may be made here upon adoption of Commonwealth budget. Reserved capacity for Hospital or Rehabilitation Care is currently in the P/FDS waiver and has not changed. The waiting list initiative will be added when or if ODP is granted a waiting list initiative.
B-6-a of the waiver applications require ODP to specify the minimum number of services that a person must receive in order to be determined as needing waiver services. A person still must receive at least one service in addition to Supports Coordination. What has changed has changed with this waiver application is that each individual must receive waiver services a minimum of two times per year to remain eligible.
B-6-c, you will see that there are some changes in terminology. In the previous waivers the professional that did the qualifications for the initial evaluation of waiver participants was called the QIDP or the qualified intellectual disability professional, the terminology will now be a QDDP, a qualified developmental disability professional. So the degree and experience requirements remain the same but the qualified professional will have to have experience working with persons with developmental disabilities versus intellectual disabilities.
So in B-6-f, this is the Process for Level of Care Evaluation or Reevaluation, again, to address the addition of autism and the birth to 7 developmental disabilities to the eligibility categories, ODP also includes additions in B-6 for the initial evaluation process and the reevaluation process. A change here is that ODP is proposing that the MA-51 is no longer required for the re-evaluation.
Okay, and now we are going to move on to Appendix C which are Participant Services. Appendix C is designed to answer the question: “What services does the waiver offer?” In this Appendix, the state establishes the specifications for each waiver service and any limitations that apply to a service or the overall amount of waiver services. This Appendix also captures information about state policies concerning criminal history or background and abuse registry checks, payments to legally responsible individuals for the provision of personal care and to relatives and legal guardians for the provision of services, and the 1915(c) home and community-based setting requirements.

For individuals who are 0-22 years of age waiver services may only be provided when they are not covered by the Early and Periodic Screening, Diagnosis, and Treatment or EPSDT benefit under the Medical Assistance program. So certain services that are not covered include things like family and caregiver training and support, home and vehicle accessibility adaptations and in-home and community support. So those are things that could be provided through the waiver that are not covered by the Early and Periodic Screening, Diagnosis, and Treatment benefit.
### New Services

**Support families throughout the life span and expand options for community living**
- Supported Living (Consolidated Only)
- Housing Tenancy and Tenancy Sustaining Services
- Family/Unpaid Caregiver Training and Consultation

**Promote self-direction, choice and control**
- Participant-Directed Goods and Services (P/FDS Only)

**Assure effective communication**
- Communication Specialist

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On the next two slides you will see a list of new services proposed for the Consolidated and P/FDS Waivers. We will get into more detail about some of these services in later slides but these two slides were meant to show you how they were developed based on Everyday Lives recommendations to address gaps in our current array of services.

Supported Living, which is only proposed for the Consolidated waiver, Housing Tenancy and Tenancy Sustaining services, and Family/Unpaid Caregiver Training and Consultation have been developed to support families throughout the life span and expand options for community living.

Participant-Directed Goods and Services, which is only proposed for the P/FDS Waiver, will promote self-direction, choice and control.

The Communication Specialist service will help assure effective communication.
Consultative Nutritional Services and Art, Music and Equine Assisted Therapy are designed to help promote the health, wellness and safety of individuals and support people with complex needs.

Community Participation Supports, Advanced Supported Employment, and Benefits Counseling are designed to increase employment and increase community participation.

Keep these Everyday Lives recommendations in mind because they influenced changes to current service definitions that we will discuss a little bit as well.
The following services are currently in both the Consolidated and P/FDS waivers and have few or no proposed changes:

- Homemaker/Chore
- Specialized Supplies
- Vehicle Accessibility Adaptations

The following services are currently in both the Consolidated and P/FDS waivers and have few or no proposed changes: Homemaker/Chore, Specialized Supplies and Vehicle Accessibility Adaptations. Due to the large amount of changes being proposed in these waivers, we wanted to point out the services where few, if any, changes have been made.
The waivers include four employment services. Two new services are being proposed: benefits counseling and advanced supported employment. The CMS Home and Community-Based Settings Rule, the governor’s employment first executive order, and the Everyday Lives recommendations all stress the importance of opportunities and support for competitive integrated employment. These services have been developed to assist individuals in their pursuit of and ability to maintain a competitive integrated job.

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<th>Employment Services</th>
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<td>Benefits Counseling - New</td>
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Supported Employment services are direct and indirect services that are provided in a variety of community settings for the purposes of supporting participants in obtaining and sustaining competitive integrated employment. Supported Employment services consist of three components: career assessment, job finding or development, and job coaching and support.

Career Assessment is new. This is a person-centered, individualized employment assessment used to assist in the identification of potential career options, including self-employment, based upon the interests and strengths of the participant. Career assessment may include discovery activities.

Career assessment includes:
- Gathering and conducting a review of the participant’s interests, skills, and work or volunteer history;
- Conducting situational assessments to assess the participant’s interest and aptitude in a particular type of job;
- And identifying types of jobs in the community that match the participant’s interests, strengths and skills.

Also new is a provision that Companion services may be provided at same time as Supported Employment for Activities of Daily Living when they cannot be provided by co-workers or natural supports.
When looking at the service definition, you will also see some proposed changes to staffing ratios. Career assessment and job finding or development may be provided at a basic level which is the provision of the service at a staff-to-individual ratio of 1:1.

Job coaching and support may be provided at the following levels:
Basic which is the provision of the service at a staff-to-individual ratio range of 1:2 to 1:4 individuals.
Level 1 is the provision of the service at a staff-to-individual ratio of 1:1.

In the provider qualification section of the Supported Employment service definition you will also see some proposed new certification requirements. Certified Employment Support Professional or CESP credential from Association of People Supporting Employment First or APSE, or a Basic Employment Services Certificate of Achievement or a Professional Certificate of Achievement in Employment Services from an Association of Community Rehabilitation Educators or ACRE organizational member that has ACRE-approved training.
When not provided with any other employment service (Transitional Work or Community Participation) and the participant is not competitively employed, the hours of authorized Supported Employment cannot exceed 40/week.

- When not provided with any other employment service and participant is competitively employed or when services are provided in conjunction with Community Participation and/or Transitional Work the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 50 hour/week.

When not provided with any other employment service (Transitional Work or Community Participation) and the participant is not competitively employed, the hours of authorized Supported Employment cannot exceed 40 per week.

People who are working or seeking work using a supported employment service may receive some additional hours of support, they may receive up to 50 hours of any combination of Community Participation, Transitional Work, and other employment services.
Advanced Supported Employment is a new proposed service. This is an enhanced version of supported employment services. The service includes discovery, job development, systematic instruction to learn the key tasks and responsibilities of the position, and intensive job coaching and supports that lead to job stabilization and retention.

Discovery involves a comprehensive analysis of the person in relation to following:
• Strongest interests toward one or more specific aspects of the labor market;
• Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment;
• Conditions necessary for successful employment or self-employment.

Eligibility for Discovery under Advanced Supported Employment is limited to participants whose preferences, skills, and employment potential cannot be best determined through traditional, standardized means due to the impact of their disability. Specifically, the individual:
• Has been found ineligible for or has a closed case with OVR services and chooses not to be re-referred, and
• In the past 2 years, with the use of supported employment services, has not been able to secure a competitive integrated job or has not been able keep a competitive integrated job for more than 6 months, and
• Meets one of the following criteria:
  o Is currently in an activity receiving a sub-minimum wage, or
  o After consulting with a credentialed provider, it is the opinion of the ISP team
that the level of support provided through this service is needed to secure sustained competitive integrated employment.

Eligibility shall be determined by the ISP team. The process that was undertaken to determine eligibility and its outcome shall be documented by the Supports Coordinator.

Advanced Supported Employment will be paid on an outcome basis. Providers will be paid for three separate outcomes.
1. The production of a detailed written Discovery Profile.
2. A job evidenced by an offer letter or other documentation from an employer offering the participant employment that meets the definition of competitive integrated employment.
3. Successful retention on the job for at least seven months.
Transitional Work services are currently in both waivers. Some proposed changes include:

• Work that participants perform during the provision of Transitional Work services must be paid at least minimum wage and the compensation must be similar to compensation earned by workers without disabilities performing the same work.

• Defined Affirmative Industry - a business that sells products or services where at least 51% of the employees do not have a disability.

• Transitional Work includes supporting the participant with personal care needs that cannot, or would be inappropriate to, be provided with the support from coworkers or other natural supports.

• Transitional Work services may not be provided in excess of three uninterrupted years.

The other limitations on the amount of Transitional Work services a person can receive are the same as for Supported Employment. And when you look at the proposed service definition you will also see new provider qualification requirements which are the same as Supported Employment.
Benefits counseling is proposed as new service in both waivers. When unavailable or unavailable in a timely fashion through the Work Incentive Planning and Assistance Programs, individuals who are working or seeking work may receive counseling to assist them to understand how work may impact benefits and how to keep benefits while working if they will continue to need them to live in home and community settings.

Through accurate individualized assessment, this service provides information to the participant regarding the full array of available work incentives for essential benefit programs including Supplemental Security Income or SSI, Medicaid, Medicare, housing subsidies, food stamps, etc.

This service is limited to 10 hours per year.
Now we will move into Day Services where we have a new service called Community Participation Supports.
Community Participation Supports replaces the current Prevocational and Day Habilitation Services. ODP has designed a Community Participation service to promote community participation in day services, improve participant opportunities, and comply with the CMS rule. Participants and families have expressed the desire for greater opportunities for participation in the community and preparation for employment for people who are interested in working. The CMS Home and Community-Based Settings Final Rule requires settings to support full access to the general community with a transition to implementation by March of 2019. Settings that restrict access to community activities of a persons choosing will no longer be eligible for Medicaid waiver payment.

Given that, this new service will allow more flexibility for individuals and for providers. It is designed to flexibly wrap around and support community life secondary to employment as the primary goal. This service involves participation in integrated community settings, in activities that involve persons without disabilities who are not paid or unpaid caregivers.

The service has standards for participation in integrated community settings that will be phased in. The phase in schedule is on your screen,

- beginning January 1, 2018 the expectation for this umbrella service is that 25% of the individuals time will be spent in community locations,
- By July 1, 2018, 50% of the individuals time would be spent in community locations,
- And by January 1, 2019, 75% of the individuals time would be spent in community locations.
This service should result in the person increasing potential for employment, developing and sustaining a range of valued social roles and relationships, building natural supports, increasing independence, and experiencing meaningful community participation and inclusion.
Activities are expected to increase the person's opportunity to build connections within his or her local community and include (but are not limited to) the following supports for:

- Prevocational skill development.
- Building and maintaining relationships and social networks.
- Selection and participation in community activities, volunteer activities, groups, associations, or clubs to develop social networks with community organizations and clubs.
- Opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health and wellness.
- Opportunities focused on training and education for self-determination and self-advocacy.
- Learning to navigate the local community, including using transportation.
- Assisting individuals with disabilities and family caregivers with providing mutual support to one another (through service/support exchange) and contributing to others in the community.
For people who have medical or behavioral support needs that affects their ability to participate in the community locations at the standards specified, there is an exception process.

In addition, there is a new limitation proposed in the waiver, in the Consolidated Waiver, there’s a proposed limit of 14 hours per day of In-Home and Community Support, Companion and Community Participation Supports whether used alone or in any combination with one another. So those three services, In-Home and Community Support, Companion and Community Participation, in the Consolidated Waiver there is a proposed limit of 14 hours—any combination of those.

Again, there will be an exception process where there are medical, mental health, or behavioral needs or conditions that impact the person’s ability to maintain health and safety.
For residential services, again this is Consolidated only, there are three residential services. ODP is proposing a new service, Supported Living, and Life Sharing is being pulled out of residential habilitation—that service definition—and is now included as a separate service definition.
For Residential Habilitation, ODP is establishing a fee schedule. The transition to the fee schedule is planned for January 1, 2018 and this transition is intended to provide a clear linkage between a person’s needs and a provider’s payment. The payment will also ensure that providers are compensated for serving people with high service needs. ODP payments for residential services will be based on an individual’s needs rather than the needs of the full group of people living in a facility. More information on the rate structure for Residential Habilitation will be available when appendices I and J are released.

The proposed Residential Habilitation service definition has also been enhanced to provide a lot of the same expectations that are included in the Home and Community Habilitation service definition approved this past July 2016. One example is providing assistance and support that enables participants residing in the same home to develop and manage relationships as appropriate, share responsibilities for shared routines such as preparing meals, eating together, carrying out routine home maintenance such as light cleaning, or planning and scheduling shared recreational activities and other typical household routines. This includes resolving differences and negotiating solutions.

The proposed service definition will also assume that clinical services such as nursing and behavioral support are included in the rate paid to providers of residential habilitation services. As such, Additional Individualized Staffing is proposed to be no longer be available as an add on services as of January 1, 2018.

The proposed service definition also includes the CMS HCBS Settings requirements that
individuals have rights to the following:
1. A legally enforceable agreement such as the lease or residency agreement for the physical space, or ownership of the physical space, that offers the same responsibilities and protections from eviction that tenants have under the Commonwealth’s Landlord and Tenant Law of 1951.
2. To receive scheduled and unscheduled visitors, and to communicate and meet privately with individuals of their choice at any time.
3. To send and receive mail and other forms of communication, unopened and unread by others.
4. To have unrestricted and private access to telecommunications.
5. To manage and access his or her own finances.
6. To choose any individual with whom they will be sharing a bedroom.
7. To furnish and decorate his or her bedroom and the common areas of the home.
8. To lock his or her bedroom door.
9. To decide what to eat, decide when to eat and have access to food at any time.
10. To make informed health care decisions.

In addition, it’s proposed that residential habilitation settings enrolled on July 1, 2017 or later shall not be located adjacent or in close proximity to another human service residential facility, another human service day facility serving primarily persons with a disability, a hospital, a nursing facility, a health or human service public or private institution.

Residential habilitation settings enrolled on July 1, 2017 or later shall not be located in any development or building where 10% or more of the apartments, condominiums or townhouses are waiver funded Residential Habilitation, Life Sharing and Supported Living—in complexes of 10 or more housing units.
Life Sharing. On this slide you will see that we have proposed to take Life Sharing out of the Residential Habilitation service definition and give it its own service definition. This service definition proposes to allow Life Sharing in the individual’s own home, the home of a relative or the home of an unrelated individual and receive agency-managed services. This is a change because to date Life Sharing has only been allowed to be provided in the home of an unrelated individual. The service definition now proposes to allow relatives who meet the qualification standards to provide services to individuals who are age 18 and older.

Similar to Residential Habilitation services, ODP is establishing a fee schedule for Life Sharing to provide a clear linkage between the person’s needs and a provider’s payment. The payment will also ensure providers are compensated for serving people with high service needs.

Also similar to Residential Habilitation services, the proposed Life Sharing service definition also includes the CMS Home and Community-Based Settings requirements related to rights with the except of the lease agreement. Other standards included in the Life Sharing definition are related to the settings being integrated in and disbursed in the community.
We have a new service called Supported Living being included in the Consolidated waiver. Supported Living is an independent living option provided to individuals who live in a private home that is owned, leased or rented by the individual and receives direct and indirect services that are agency managed. Supported Living provides a cost-efficient residential habilitation option for individuals with less intense needs. This service is billed as a day unit and assumes that there are periods of time that the participant does not need direct paid service in his or her home and community. The Supported Living provider must ensure that on-call staff are available to support the participant 24 hours a day. This service encourages rather than displaces natural supports and provides participants with the option of selecting one or two roommates to share living costs and staffing resources.
Supported Living will be billed as a day unit and could support 1, 2 or 3 people living together in a private home. The service is provided at the following levels; for each person the rates are structured at:

- Up to 20 hours per week on average of direct support
- 21-40 hours per week on average of direct support
- 41-60 hours or
- 60 or more hours per week for the participant. There will only be a rate for 60 or more hours per week in two person or three person home
Now we are going to go over changes the Technology and Adaptation services. While you will see Vehicle Accessibility Adaptations listed on this slide, we will not be going over this service as there have been few or no proposed changes to the service.
Assistive Technology. This service is currently in both waivers but there have been some changes as noted on this slide. While remote electronic monitoring services and independent living technology is covered in the current waivers, ODP is clarifying that these specific services are for people who are ages 16 and older. Examples of independent living technology include, but are not limited to: medication dispensers, door sensors, window sensors, stove sensors, water sensors, pressure pads, GPS Tracking Watches, panic pendants, and the remote monitoring equipment necessary to operate the independent living technology.

When you review Assistive Technology service definition, you will also see that prior to purchasing and installing remote monitoring equipment, the Independent Living Technology provider is responsible for the completion of the following:

- an evaluation plan that at a minimum includes the needs of the participant that will be met by the technology, how the technology will ensure the participants health, welfare and independence, the training needed to successfully utilize the technology, and the backup plan that would be implemented should there be a problem with technology
- a cost benefit analysis for all options
- an outcome monitoring plan that outlines the outcomes the participant is to achieve by using Independent Living Technology, how the outcomes will be measured and the frequency that the monitoring will be completed which must be at least quarterly and more frequently if needed
- and informing the participant and anyone identified by the participant of what impact the Independent Living Technology will have on the participants privacy.
There are a number of proposed limitations on the assistive technology service as you can see in this slide.

There is a proposed lifetime limit of $10,000 per participant for all assistive technology except remote monitoring services. This limit may be extended by ODP using the standard ODP exception process. This lifetime limit includes a lifetime limit of $5,000 for generators. While generators have a separate lifetime limit, the amount spent on a generator is included in the overall assistive technology lifetime limit of $10,000. It also includes electronic devices, remote monitoring equipment utilized as part of independent living technology, and repairs, warranties, ancillary supplies, software, and equipment.

There is an additional annual limit of $5,000 for remote monitoring service completed as part of independent living technology. This limit is not included in the overall assistive technology lifetime limit of $10,000.

And no more than one replacement electronic device is allowed every 5 years.
Home Accessibility Adaptations are also included in both waivers. In the draft waiver applications, ODP is proposing an exception to the $20,000 limitation for home accessibility adaptations when approved by ODP for any of the following situations:

- Maintenance or repair to existing home accessibility adaptations when it is not covered by warranty or home owners insurance and the maintenance or repair is more cost-effective than replacing the home accessibility adaptation.
- Track lift systems that exceed the limit and will reduce the need for other services.
The waivers contain numerous behavior and medical support services as seen on this slide.

<table>
<thead>
<tr>
<th>Therapies</th>
<th>Shift Nursing</th>
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<tbody>
<tr>
<td>Music and Art Therapy and Equine Assisted Therapy - NEW</td>
<td>Consultative Nutritional Services - NEW</td>
</tr>
<tr>
<td>Behavioral Support</td>
<td>Specialized Supplies</td>
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</table>
First we’ll go over the therapies. The waivers still include Speech Therapy, Physical Therapy, Occupational Therapy and Visual/Mobility Therapy. Behavior Therapy, which is a different service than Behavioral Support, was removed because it is covered through medical assistance.

The waiver now includes requirements that therapies must be delivered in a home and community-based setting and cannot be provided in a clinic or rehabilitative facility setting because those services are provided—they are covered through Medical Assistance in clinic or rehabilitative facility settings.
The Nursing service will be called Shift Nursing and in the Consolidated waiver there will be two changes for the Shift Nursing service. Individuals receiving Residential Habilitation, Life Sharing or Supported Living may not receive shift nursing as the clinical services are built into the rate for the service and are to be provided by the residential provider effective January 1, 2018.

There is also a change to the ratios. The current waivers have a nursing ratio of one nurse to one individual and we are adding a ratio of one nurse to two individuals when that makes sense for the individual.
ODP is also proposing a new service called Consultative Nutritional Services.

This service is intended to assist unpaid caregivers and/or paid support staff in carrying out participant treatment/service plan. The service may include assessment, the development of a home treatment/service plan, training and technical assistance to carry out the plan and monitoring of the participant and the provider in the implementation of the plan.

- Not available for people receiving residential services
- Not available for people <21, EPSDT service
- Limit of 48 units annually

Consultative Nutritional Services will not be available for people receiving residential services. Consultative Nutritional Services will also not be available for individuals who are under the age of 21 as this in an EPSDT covered service.

And there is a proposed limit of 48 units or 12 hours of annual Consultative Nutritional Services.
Behavior Support service is currently in both waivers and has some proposed changes as well. We are proposing that there be two levels of service available depending on the person’s level of need.

Level 1 is very similar to what is currently in the Behavioral Support service definition and it requires that the professional have a Master’s in Human Services or a related field or a Bachelors’ Degree and work under the supervision of an individual with a Master’s Degree.

Level 2, however is new—newly proposed in the waivers, it’s for participants who have demonstrated complex needs, including regression or lack of adequate progress with Level 1, or the individual is at high risk for decreased stability in the absence of Level 2 support. Providers of Level 2 must have a Master’s in Human Services or a related field or be a licensed psychiatrist, psychologist, professional counselor, social worker, or hold a behavior specialist license.
Individuals receiving Residential Habilitation, Life Sharing or Supported Living may not receive Behavioral Support as clinical services are built into the rate for the service and are to be provided by the residential provider starting January 1, 2018.
Music, Art, and Equine Assisted Therapy is a new proposed service for both waivers. The service is designed to help promote the health, wellness and safety of individuals and support people with complex needs. Music, Art and Equine Therapy is a direct therapy to maintain, improve or prevent regression of the individual’s condition and assist in the acquisition, retention or improvement of skills necessary for the individual to live and work in the community.

Music and Art Therapy can only be provided to adult participants or those who are over age 21 as it is covered under the EPSDT benefit for individuals who are under the age of 21. Equine Assisted Therapy can be provided to participants of any age as it is not covered by Medical Assistance.

Participants authorized to receive Music Therapy, Art Therapy, or Equine Assisted Therapy may not be authorized to receive Residential Habilitation services. And there is a proposed cumulative annual limit of any combination of Music Therapy, Art Therapy, or Equine Assisted Therapy of 104 fifteen-minute units.
There are eleven additional services to support people in home and community based settings that are in the proposed applications Appendices A through H* in the Consolidated and P/FDS Waivers. And we are going to go through each of these in the next set of slides.

*Audio incorrectly states appendices A through F.
Starting with Education Support Services. The proposed changes to the waivers include clarification that Education Support services are limited to payment for the following:

- Tuition for adult education classes offered by a college, community college, technical school or university. At least 75% of the time spent on campus must be integrated with the general student population.
- General fees charged to all students (technology fees, student facilities fees, etc.)
- On campus peer support, institution of postsecondary education’s staff who assist the participant to learn roles or tasks related to the campus environment (homework assistance, interpersonal skills, etc.)
- Classes to teach participants who are deaf.
- Adult education or tutoring program for reading or math instruction.
Education Support services cannot pay for:

- room and board,
- books,
- recreational classes, activities and programs that are offered through recreational commissions, townships, or boroughs,
- cannot pay for adult education classes offered by online universities,
- adult education classes provided on disability specific campuses are also not covered under this service.

Other limitations on this service are that the waiver participant is limited 120 credit hours in a lifetime covered under the waivers and/or $5,000 per semester of on campus peer support; and that is limited to when a student is taking at least 6 credit hours.
For, there is a new service proposed—this is another new service and it is called Family/Caregiver Training and Support. It covers direct training and counseling services for unpaid family members or caregivers. The service is intended to develop, strengthen and maintain healthy and stable relationships among the participant and all members of the participant’s informal network, and to support achievement of the goals in the participant’s service plan.

Family/Caregiver Training and Support also assists the individual's unpaid family member or caregivers with developing expertise so that they can help the person acquire, retain or improve skills that lead to meaningful engagement and involvement with others and in the community.

There are different limits for the two components of the service. The service is limited to 20 hours per fiscal year and the amount of training or registration fees for the unpaid family member or caregivers. That’s things like registrations costs at specific training events or workshops or seminars. That limitation is $500 per fiscal year. So 20 hours for the hourly service and $500 per fiscal year provided that the formal instruction is relevant to the participant’s needs as identified in the service plan. These costs cannot be used for lodging, meals or transportation; just for the fees for the training or the conference.
There’s another new service called Housing Transition and Tenancy Sustaining Service and this includes pre-tenancy—so before the individual moves into a house—and housing sustaining supports to assist participants in being successful tenants in private homes that are owned, rented or leased by the individual.

Housing Transition services are direct services provided to individuals. Examples of the activities that are covered are:

- Conducting a tenant screening and housing assessment that identifies the participant’s preferences and barriers related to successful tenancy.
- Developing an individualized housing support plan based upon the housing assessment that addresses the barriers, includes both short and long-term measurable goals for each issue, establishes the person’s approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
- Other activities might be assisting with the housing search process.
- Or assisting with completing the housing applications, including applying for housing vouchers.
- Might be identifying resources to cover expenses such as security deposits or moving costs, furnishings, adaptive aids or environmental modifications, moving costs and other one-time expenses.
- Other activities might be ensuring that the living environment is safe and ready for move-in.
- And assisting in arranging for and supporting different details or logistics of the move.
• It might be developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized to really assist that individual with planning, locating and maintaining a home of their own.
This service is also available to support participants to not just obtain but to maintain tenancy in a private home owned, leased or rented by the individual. The availability of ongoing housing-related services in addition to other long term services and supports promotes housing success, fosters community integration and inclusion, and develops natural support networks.

These tenancy support services are things like:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
- It may include education and training on the role, rights and responsibilities of the tenant and the landlord.
- It may involve coaching on developing and maintaining key relationships with landlords or property managers with a goal of fostering successful tenancy.
- It may include assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
- And it may include advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized.

There is a proposed limit on this service of 160 hours per fiscal year for both the Transition and Tenancy Sustaining service.
With Respite, the service is currently in both the Consolidated and P/FDS. There are some proposed changes to the service definition.

First, nursing will no longer be covered under the Respite service. Nursing can still be covered under Shift Nursing that Julie covered a little while ago. Respite can be provided in a private ICF or Nursing Facility when the individual has documented medical or behavioral needs and is unable to locate a community-based respite provider.

And when appendices I and J are released, you will see that there are some changes in the rate structure for respite and these changes were intended to expand options like licensed respite homes to make sure that they are available to individuals and their caregivers.
There’s some changes to the limitations in the Respite services.

So currently there are limits on the number of day unit respite and 15-minute unit respite that an individual can receive. Those limits have not changed for individuals who get respite through a traditional agency. ODP is proposing, however, that individuals who self-direct their respite be limited to a dollar cap and that cap is $8,000 per year. This means that individuals who self-direct their respite will have more flexibility in how they use the respite service. The individual may choose how many 15-minute and day respite units to utilize based on their needs. They can do this during the year as long as the total amount of respite does not exceed the $8,000 limit and the amount approved on the participant’s service plan.

The proposal is that individuals must choose one model through which to receive Respite services either participant direction or traditional agency provider and use the limits specified for the model they have selected.
There is a new service proposed for the P/FDS Waiver only. The service is called Participant-Directed Goods and Services. Participant-Directed Goods and Services are services, equipment or supplies not otherwise provided through other services offered in the waiver, the Medicaid State Plan/Medical Assistance, or a responsible third-party like another insurer. Participant Goods and Services must address an identified need in the participant’s service plan and must achieve one or more of the following objectives:

- they must decrease the need for other Medicaid services;
- Promote or maintain inclusion in the community;
- Promote the independence of the participant;
- Increase the participant’s health and safety;
- Develop or maintain personal, social, physical or work-related skills;
- And items and services must be used primarily for the benefit of the participant.

Again, this service is only for people on the P/FDS waiver. And there is an annual limit of $2,000 per person.
Another new service that is being proposed in the waivers is a service that support individuals with nontraditional communication needs. It is the Communication Specialist services. This service assists people by determining communication needs, educating the individual and his or her caregivers on the person's communication needs and the best way to meet those needs in their daily lives. Some examples of activities covered by this service are:

• Reviewing the individual's communication needs, including but not limited to the person’s current methods of communication, the person’s preferred methods of communication, supplementary communication methods that he or she may have, and communication methods that have proven to be ineffective in daily communication
• Another example would be educating caregivers in the participant’s current and preferred communication needs
• And helping to establish environments that emphasize the use of visual cues and other appropriate communication methods as recommended by a Speech-Language pathologist or other qualified professional

For the purposes of this service, what ODP means by “nontraditional communication” includes the use one or more of the following communication methods: Sign Language, including American Sign Language or Sign Language from other countries, such as Spanish Sign Language; Lip Reading; Visual-Gestural Communication; Paralinguistics; Haptics or Touch Cues; Artifacts, Texture Cues, or Objects of Reference; Braille; Print and Symbol Systems; Speech, Voice and Language Interpretation; Eye-Gaze and Partner-Assisted Scanning; Or other communication methods that are identified by the Department.
For Supports Broker Service, which is available in both waivers, there have been no major changes to this service definition. There is a proposed change in the qualification requirements and that is that the supports broker must complete a Supports Broker Certification Program that will be provided by ODP or its designee within 18 months of enrollment as a provider or within 18 months of the effective date of the waiver.
As with Supports Broker, there are no major proposed changes to the service definition for Supports Coordination. There are quite a few changes to the provider qualification requirements for Supports Coordination. These include that the:

- Executive Director must have 5 years of professional experience in the field of disability services, including 3 years of administrative, supervisory, or consultative work; and a bachelor’s degree
- Have a written conflict of interest policy for their Board of Directors and employees
- Have an orientation program that includes:
  - Person-centered practices
  - The prevention, detection and reporting of abuse, suspected abuse and alleged abuse
  - Individual rights and recognizing and reporting incidents.
Additionally for Supports Coordination, there are other requirements that the personnel must be employees of the SCO (extraordinary circumstances for temporary contracts). SC Supervisor can supervise a maximum of 7 Supports Coordinators.

Qualification standards for SC Supervisors
- Complete 24 hours of training each year

Qualification standards for SCs
- Complete 24 hours of training each year

For SC Supervisors, the qualification standards now indicates that there must be 24 hours of training completed annually. And for SC’s, there also is a requirement to complete 24 hours of training each year.
For the Transportation service that is currently in both waivers, that will continue to include transportation mile, transportation trip and public transportation. There are some proposed changes which include:

- Transportation Mile – Mileage will be paid per trip versus round trip. A trip is from the point of pick-up to the destination as identified in the service plan.

- For participants under the age of 21, Transportation may only be used to travel to and from waiver services or a job that meets the definition of competitive integrated employment.

- Participants authorized to receive Residential Habilitation, Life Sharing or Supported Living may only be authorized for Transportation services as a discrete service when the participant requires transportation to or from a job that meets the definition of competitive employment.

For the Transportation service that is currently in both waivers, that will continue to include transportation mile, transportation trip and public transportation. There are some proposed changes which include:

- that transportation mile will be paid per trip versus per round trip. A trip is from the point of pick-up to the destination as identified in the plan;

- for individuals under the age of 21, any of the types of transportation may only be used to travel to and from waiver services or a job that meets the definition of competitive integrated employment;

- and finally to promote employment, individuals authorized to receive Residential Habilitation, Life Sharing or Supported Living may only be authorized for Transportation services as a discrete service when the participant requires transportation to or from a job that meets the definition of competitive integrated employment.
And our last service definition to cover here is In-Home and Community Supports which was previously Home and Community Habilitation. So first, we propose to change the name of the service to In-Home and Community Support. The service definition also proposes changes to the staffing ratios with the highest ratio being 1 staff to 4 individuals versus the current 1 staff to 6 individuals in the current waivers.

Another change that’s proposed is that transportation necessary to enable community activities in accordance with the individual’s service plan that is 30 miles or less per day during when the service is being provided is included in the rate. When the In-Home and Community Support professional transports a participant more than 30 miles per day to enable community participation, only the mileage that is in excess of 30 miles should be authorized and billed as Transportation Mile. In these situations, In-Home and Community Support and Transportation Mile are compensable at the same time.

The service definition also proposes that an individual receive a maximum of 14 hours per day of any combination or individual use of these three services: In-Home and Community Support, Community Participation Support and/or Companion. There will be an exception process to this limit when there are medical, mental health or behavioral needs or conditions that affects the person’s ability to maintain health and safety.
Changes have been proposed in Appendix C of the renewals beyond the service definitions. Appendix C-2-d talks about personal care or similar waiver services that can be provided by legally responsible individuals. In regard to the waivers, a legally responsible individual is a person who has legal obligation under the provisions of law to care for another person including parents of minor children under the age of 18 and legally-assigned relative caregivers of minor children.

The only waiver service legally responsible individuals can provide that has personal care components is In-Home and Community Support when the following conditions are met:

1. the service is considered extraordinary care. A parent is legally responsible to meet the needs of a minor child, including the needs for assistance and supervision typically required for children at various stages of growth and development. A parent can, however, receive payment for In-Home and Community Support when the support goes beyond what would be expected to be performed in the usual course of parenting and when needed support exceeds what is typically required to care for a child of the same age;

2. the service would otherwise need to be provided by a qualified provider of services funded under the waiver;

3. the legally individual is not the common law employer or managing employer for the participant that they will provide the services to; and

4. the service is provided by a legally responsible individual who meets the qualification criteria that are established by ODP.
The service definition for In-Home and Community Support outlines limits for the number of hours that legally responsible individuals, relatives, or legal guardians may provide the service.
Appendix C-2-e discusses the waiver services that relatives and legal guardians may be paid to provide. Services that relatives or legal guardians can provide are limited to the following: In-Home and Community Support, Companion, Life Sharing, Supported Employment, Nursing and Transportation Mile. Relatives and legal guardians who are not the participants’ primary caregiver may also provide Supports Broker and Respite services.

Legally responsible individuals, as we discussed in Appendix C-2-d, may also provide the following services that do not have a non-personal care component:

- Supported Employment
- Transportation Mile solely to drive a minor child to and from a waiver service or a job the meets the definition of competitive integrated employment.

Relatives, legal guardians, and legally responsible individuals may be paid to provide waiver services when the following conditions are met:

1. the individual has expressed a preference to have the relative or legal guardian provide the service or services;
2. the service provided is not a function that the relative or legal guardian would normally provide for the participant without charge in the usual relationship among members of the nuclear family;
3. the service would otherwise need to be provided by a qualified provider of services funded under the waiver;
4. the relative or legal guardian is not the common law employer or managing employer for the participant that they will provide the services to and the only service a common
law employer or managing employer may receive payment for is Transportation Mile;
and
5. the service is provided by a relative or legal guardian who meets the qualification criteria
that are established by ODP.
This slide is for the P/FDS Waiver only where the limit on the amount of services is explained in Appendix C-4. As you may know, the current P/FDS waiver has a $30,000 limit on waiver services in a fiscal year. In the proposed P/FDS waiver you won’t see a limit yet. ODP will establish the limit once the rates have been established for all P/FDS waiver services. We anticipate releasing this section of the waiver with a proposed dollar limit with Appendices I and J in January.

Whatever the proposed limit, we also propose to continue to exclude Supports Coordination and Supports Broker services because they are integral to ensuring the success of participants in utilizing traditional service models and participant directed service models.

We also proposed to allow the established limit to be exceeded by $15,000 for Advanced Supported Employment or Supported Employment
Appendix C-5 was added to the waiver applications for states to document compliance with the CMS Home and Community Based Settings Rule. In this section states are to describe the settings where waiver participants reside, where waiver services are provided, and how these settings meet the Home and Community Based Settings requirements.

In this appendix, ODP explains that in order to meet the federal HCBS settings standards, the Supports Coordinator is responsible for using a person centered planning approach and a team process to develop the participant’s service plan to meet the participant’s needs in the least restrictive manner possible. This includes ensuring that services provided in the participant’s private home and community as well as all residential and non-residential settings are integrated in and support full access to the community.
In alignment with federal regulations, ODP has included details about the settings in which waiver services cannot be provided. These settings include farmsteads and gated communities designed specifically for people with disabilities.

So when we talk about a farmstead we are not saying that any person who lives on a farm in ineligible to receive waiver services. A farmstead is where people who live at the farm typically interact primarily with people with disabilities and staff who work with those individuals. Participants typically live in homes only with other people with disabilities and/or staff. Daily activities are typically designed to take place on-site so that a participant generally does not leave the farm to access services or participate in community activities. While sometimes people from the broader community may come on-site, participants from the farm do not go out into the broader community as part of their daily life.

And when we talk about a gated or secured community for people with disabilities, we’re talking about communities that consist primarily of people with disabilities and the staff that work with them. Once again, participants receiving services in this type of setting often do not leave the grounds of the gated community in order to access activities or services in the broader community.

Further, waiver services can not be provided in any private home purchased for, developed for, or promoted as serving people with an intellectual disability and/or Autism in a manner that isolates or segregates the participant from the community of individuals not receiving waiver services.
There is one exception for some institutional settings and that is for ODP will permit respite to be provided in institutional settings for a duration that does not exceed 30 days and you will see that in the respite service definition.
So Appendix D, Participant Centered Planning and Service Delivery.
So let’s look at D-1, the Service Plan Development and specifically at D-1-c. In this appendix, ODP has added a reference to the Community of Practice Lifecourse Framework and has noted that the Service Plan must be written in plain language and in a manner that is accessible to the participant and his or her family. There are also some language changes to clarify the Support Coordinator’s role in developing the individual’s Service Plan based on the information provided by the participant, his or her family, and invited team members.
In D-1-d, the proposed changes here for service plan development include the elimination of timing requirements for the ISP process; this is replaced with flexible language “in accordance with requirements established by ODP”. The previous waiver required meetings had to be scheduled 90 days prior and held 60 days prior to end date of ISP. Another change here is that the SIS needs assessment will also be done every 5 years instead of every 3 years as it is currently.
For D-2-a, ODP has clarified that face-to-face monitoring should not occur at the place of employment or at an educational setting without the consent of the participant. It also removed language that allows the deviation from the monitoring frequency and location requirements. A deviation of monitoring frequency is only permitted when an individual goes on vacation or on a trip as per ODP’s Waiver Travel Policy related to the Service Definitions.

For D-2-b, for participants who receive a monthly service, the Support Coordinator—this is for Consolidated, the Supports Coordinator shall conduct a face-to-face monitoring one time a month:

- One of those visits must take place at the participant’s residence;
- One of those visits must take place at the participant’s day service, including a nontraditional day program; and
- One can be at any location where an authorized service is rendered, or any location agreeable to the waiver participant.
For D-2-b in the P/FDS, for participants who receive a monthly service:

- the monitoring is to occur once every three months at a minimum, a face-to-face monitoring;
- at least one of the face-to-face monitoring visits in every six calendar months must take place in the waiver participant’s home;
- one of those visits must take place at the waiver participant's day service, including a nontraditional day program as appropriate; and
- one of the visits may take place at any location where an authorized service is rendered, or as applicable in the waiver participant’s plan or any location agreeable to the waiver participant.
Moving into Appendix E which explains Participant Directed Services. This section has very few changes.
So we have removed “Participant – Budget Authority.” This actually, you’ll see in the application, we have removed Participant Budget Authority this does not change the model in any way. We currently do not offer and haven’t offered true budget authority, so this should not have been included (Appendices E-1-b, E-1-g, and E-2-b).

• Specifies how FMS agencies are monitored, particularly that AWC FMS providers are monitored separately (Appendix E-1-i).

• Strengthened enforcement powers to allow easier termination of poorly-performing CLEs/MEs (Appendix E-1-m).

We have now specified how financial management service agencies are monitored, particularly that Agency with Choice FMS providers are monitored separately.

And we have strengthened the enforcement powers to allow easier termination of poorly-performing common law employers or managing employers and that’s in appendix E-1-m.
Okay, and now we’ll move on to Appendix F, Participant Rights.
Appendix F is where we ODP describes the policy and procedures under the waiver for informing individuals of the opportunity to request a fair hearing.

There are very few changes in Appendix F, however there are a couple of changes in Appendix F-3 which discusses the State Grievance/Complaint System. The first change is that ODP added the requirement for providers to have procedures for grievances.

And the second change is that ODP added timelines for the Customer Service Line referral and resolution. It will state:

- When a complaint or grievance is received through the Customer Service Line or by email, information relating to the complaint or grievance is obtained and entered into a database. Information collected includes, but is not limited to, the complainants contact information and the nature of the complaint. The information is then referred to headquarters staff or the appropriate ODP regional office for follow up. The complainant is contacted within 24 hours and corrective action is planned in conjunction with the Administrative Entity or provider if warranted.
Appendix G, Participant Safeguards
Appendix G-1-b, which is in response to Critical Events or Incidents. This section was just reorganized and language was added about the data system used for Incident Management, and it’s referred to as the Enterprise Incident Management or EIM system.
Appendix G-2 is regarding Safeguards Concerning Restraints and Restrictive Interventions

ODP removed language specific to licensed locations so that these requirements can be applied to private homes, and we’ve also added expectations for Human Rights Committee review of restrictive procedures. We removed previous language on Pro Re Nata (PRN) medication, as they are not chemical restraints but an intervention used to treat a diagnosed psychiatric condition. We’ve also removed language on medical devices prescribed by a physician to prevent harm as they are not considered a mechanical restraint.

In G-2-bi, we’ve also introduced Environmental restrictions as a permissible intervention.
In Appendix G-3, regarding Medication Management and Administration, ODP has added the role of the Supports Coordinator to communicate information directly to the ISP team. We have also in b-i-i, we have removed content discussing regional nurses teaching the medication administration course and added the role of regional risk managers in oversight and follow up. Changed reporting requirement to EIM rather than HCSIS. And we also note that ODP removed the sentence: “These requirements do not apply to non-licensed providers.”
We will move onto Appendix H which is the Quality Improvement Strategy.
In Appendix H some changes are that ODP proposes to consolidate required Evidence-Based Reports or EBRs for the Consolidated and P/FDS Waivers rather than submitting two separate reports to CMS. ODP also proposed that the Information Sharing and Advisory Committee or ISAC as ODP’s Stakeholder Quality Council.

Appendix H also describes how the Independent Monitoring for Quality or IM4Q Steering Committee is connected to ISAC through the submission of recommendations for action based on review of input gathered from individuals served.

In Appendix H-1-b, Other System Design Changes are that ODP’s Quality Leadership Board is replaced with ODP’s Executive Staff as the body that will review input from the Quality Oversight Groups and ISAC.
So that concludes our review of the significant changes to Appendices A through H that ODP has proposed for the Consolidated and P/FDS waivers. Now we're going to go through some of the next steps and resources to assist you with your public comment period.
So once the public comment period ends on January 17th, ODP will be reviewing all of the comments and questions received and will consider modifying the waiver renewals. ODP will be developing a summary document of the comments and the questions received along with any modifications made to the renewals based on those comments and questions.

When the final renewals are submitted to CMS in March 2017, those documents will be posted on the Department of Human Services’ website. Notification of this activity will also be sent to our stakeholders.

ODP will be releasing Appendices I and J which would then complete the waiver applications. Those cover the rates and the fiscal side of the waivers and those will be released in January. They will be made available for public comment for 30 days.
In addition to the draft waiver Appendices A through H for the Consolidated and P/FDS waivers, there are some other resources explaining the changes in the waivers on the DHS site linked on this slide. Also, there is a recorded preview of the waivers—that is a webinar—and that provides some background for many of the changes proposed as well as a high level overview of the changes. That link is also provided on the slide; that can be found on MyODP.org.

ODP has also been gathering questions that we’ve been receiving since the public comment period started on December 3rd and there is a question and answer document posted on the DHS site as well.
The public comment period for A through H began December 3rd and it does end January 17, 2017.

You can submit comments through an email; the email is RA-odpcomment@pa.gov

You can also mail in your comments to Julie Mochon at the Department of Human Services, Office of Developmental Programs, 625 Forster Street, Room 501, Harrisburg, PA 17120.

And you can certainly submit your oral comments on the webinars that are being conducted in January. We will be taking public comment in those web sessions as well.

Thank you for attending this and we hope to see your comments submitted before January 17th. Thank you.