POSITION PAPER

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"HOME CARE AGENCIES/HOME CARE REGISTRIES

ARE NOT

HOME HEALTH CARE AGENCIES"

PREFACE:

The title "HOME CARE AGENCIES/HOME CARE REGISTRIES ARE **NOT** HOME HEALTH CARE AGENCIES" was not decided upon lightly.

It is very apparent that the State/OLTL/ PA Dept. of Human Services (DHS) HAS OUT SOURCED ITS FEDERALLY MANADATED OVERSIGHT ROLE AND RESPONSIBILITIES AS PENNSYLVANIA'S DESIGNATED MEDICAID AGENCY FOR THE 1915C HCBS MEDICAID WAIVER PROGRAM TO THE THREE (3) MCO'S-MANAGED CARE ORGANIZATIONS.

The newly constituted Community Health Choices consolidates the old waivers of: Aging, Independence and Act 150/Attendant care into one, through the amendment of the CommCare waiver.

Furthermore, in doing so... THE STATE MAY VERY WELL HAVE POSITIONED ITSELF INTO A SITUATION THAT COULD COST PENNSYLVANIA (IF NOT ALL) OF THE FEDERAL FUNDING FOR 1915c HCBS – HOME AND COMMUNITY BASED SURPPORTS WAIVER PROGRAMS.

IN ESSENCE THE APPROVED WAIVER.... the CHC- Community Health Choices waiver : effective (1/1/2018), represents the State's comprehensive SERVICE DELIVERY PLAN... a detailed BLUE PRINT.... That is used by CMS-Centers for Medicaid Services to evaluate/ENSURE that the State's .... On a on-going basis ... is administering, managing and directing each individual player (MCO's (as defined), each individual Service provider (as defined) and the individual Participant/Consumer (as Defined) is authorizing, rendering and receiving each individually approved service (as defined) as DEFINED and in the manner articulated in the waiver (Service Plan). In essence the State MUST clearly articulate HOW the State WILL :

1 Transition targeted populations under this new waiver construct.

2 Detail "HOW" :

: the State expects the Administrators (the MCO's) to MANAGE the waiver

: Defines each individual "SERVICE" offered under the waiver

: the State DEFINES EACH "SERVICE"

: the State DEFINES THE TYPE OF PROVIDERS THAT WILL BE AUTHORIZED TO PROVIDE EACH "SERVICE"

: the State defines /establishes what (if any) credentials/licenses ARE required by EACH PROVIDER TYPE to provide the "service(s)" they are authorized / Licensed to provide

: the State sets clearly articulated quality evaluation practices that will employed to

ensure that EACH "SERVICE" is provided in the manner that it was intended.

So that each individual consumer is afforded consistently clear information by which to make Life choices about how , who and how they (the individual Consumer/Participant) wants to receive ANY of the "services" provided to them. This is called making INFORMED DECISIONS.

The waiver acts as a descriptive guidance to administrators and provider alike in detailing "how this waiver format and program is supposed to work. In essence the waiver application is the "SERVICE PLAN"... Through this application and evaluation process, the approval of the waiver as stated in the application.... that articulates to the users: administrators, managers, all provider types , as well as each individual participant/consumers as to how each "SERVICE" as defined and stated in the waiver application will be (on an on- going basis) be managed and provided to each individual/participant FULLY and with EQUAL ACCESS to ALL approved individuals as defined in the "TARGET POPULATION" of that waiver.

The State KNEW ... by virtue of going through the application process, that it would have several discussions with CMS to ensure MANDATORY ASSURANCES were met and clearly articulated in its respective Appendices /parts of this waiver in order to secure its approval. Further that there are fundamental ingredients of ; and expected responses given by the State that there were TYPE, SCOPE, FREQUENCY, AMOUNT AND DURATION format criteria.

To the point, the State had to DEFINE each individual "service" as well as each individual service delivery provider that could provide each individual "service" in such a way that it satisfied CMS's oversight obligations of ensuring that the BASIC premise of/for a HCBS-Home and Community Based Support waiver services and their provision were met and that the State had cleared away (ANY) all of the necessary BARRIERS (Legal and/or Regulatory... etc.) for each waiver services to be successfully implemented by the respective service provider. As well as ENSURE:

1) That HCBS would be provided in manner that empowered each individual participant/consumer with CONTROL over "SOME or ALL" of their approved services and

2) That "services" did not duplicate/conflict with other existing state services and

3) That "services" would be provided to each individual participant/consumer in such a way that SERVICE DELIVERY pathways would give CLEARLY DEFINED EXPLANATIONS and CHOICE of options throughout every step to each individual participant/consumer to select from in making LIFE-CHOICE decisions.

However, NOW!!!! With the rollout of the CHC- Community Health Choices 1915c HCBS waiver (effective on 1/1/2018) SERIOUS ISSUES are surfacing that question Pennsylvania's OVERSIGHT COMPLIANCE to these articulated assurances as well as how the waiver (AS APPROVED) is being administered, managed and implemented.

IF only to gain clarification regarding these ISSUES, this paper takes a critical examination of specific elements/components of this CHC waiver THAT RAISE "RED FLAGS" SUGGESTING THAT .... A

PRESUMED AUTHORITY IS allowing either the MCO's and/or through THEIR "tracking accountabilities" (VIA THE HHA Exchange) ARE MISLEADING EACH CONSUMER/PARTICIPANT .

CLEARLY 1915C HCBS WAIVERS AS THEY ARE DEFINED WITH RESPECT TO THE "SERVICE" OF PERSONAL ASSISTANCE SERVICE (PAS) ARE NOT HOME HEALTH CARE SERVICES. AS SUCH, THE SERVICE PROVISION OF PAS CAN NOT BE RENDERED BY HOME HEALTHCARE AGENCIES AS DEFINED BY PROVIDER TYPE AND BY THE "SERVICE".... AS IT IS STATED IN THE 1915C HCBS.

THIS "INSTITUTIONAL BIAS" IS OBVIOUS.... WHETHER IT IS CONSCIOUSLY done by special interest groups or league of providers that are trying to preserve that market shares OR UNCONSIOUSLY because consumers just want ample choices of providers to choose from OR consumers wants or feels more comfortable being associated with the Home Health Care label.

Regardless, the fact of the matter CMS has gone on the record in saying that waivers should focus more on what they are rather than on what they are not. That being said, what should be clearly articulated in the waivers implementation protocols .... used in their service delivery format.... IS WHAT IS CLEARLY ARTICULATED AND IN THE MANNER THAT IS ARTICULATED IN THE APPROVED WAIVER FOR EVERY SERVICE PROVIDER AND "SERVICE" PROVIDED.

UNFORTUNATELY THIS IS CLEARLY NOT THE CASE OR A CONSUMERS EXPERIENCE..... AS EVIDENCED BY .... Both face-to-face encounters with MCO Representatives who steadfastly assert and portray the MISREPRESENTATION that the 1915c HCBS waiver(s) and ALL of the "SERVICES" offered and can only be offered/provided under the HOME HEALTH CARE AGENCY MODEL.. AND

In the experience of each consumer/participant when they search for a service provider using the HHA Exchange PROVIDER SEARCH function.

THIS papers is intended to shed light on the fact that the assertion that Home Health Care Agencies CAN provide the "Service" of PAS ....IS NOT TRUE... FURTHERMORE that it was NEVER TRUE from the inception of the 1915c HCBS waiver and its governing regulations.

THE TRANSITION EXPERIENCE of a 1915c HCBS waiver PROVIDER

Respectfully stated, after speaking with each of our designated Account Representatives from: the HHA Exchange and each of the three (3) DESIGNATED MCO's- Managed Care Organizations, SEVERAL 1915c HCBS waiver COMPLIANCE ISSUES IMMEDIATELY BEGAN TO SURFACE that appears TO NOT BE ON the radar of State or DHS/OLTL or CMS.

Through my efforts in researching the various agreements, policies, guidelines, regulations (State and Federal) regarding the AMEDNED waiver as approved and promulgated by the State. That there are / were NO SUBSTANITIVE changes to any consolidated waiver as "AMENDED" and as approved under the current 1915c CHC waiver .

EXPERIENCES with the HHA Exchange and the three (3) MCO's STRONGLY INDICATE drastic SUBSTANITIVE CHANGES being made to the service definitions (as approved in the waiver) regarding the SERVICES PROVISION of the "SERVICE": Personal Assistance Services (PAS) and the TYPE of provider that CAN/IS authorized to provide that services, in my opinion, warrants some type of sounding of the alarm to CMS ... BECAUSE SERVICE PROVIDERS ARE BEING DESCRIBED in a manner that is /are NOT INCOMPLIANCE with that as stated in the approved waiver.

The identification of the originating source of/for this NON-COMPLIANCE ISSUE is NOT the purpose of this paper... but it is clear... at least as far as it involves the designation of respective PROVIDER TYPES authorized to provide the "SERVICE" of Personal Assistance Service (PAS) originates at the door of the HHA EXchange.

Furthermore when asked directly about this "inconsistency" the answer I was given.... More than 5 times from different HHA Exchange representatives.... Is that they have SET-UP the HHA Exchange as approved by each of the individual MCO's.

What is apparent is that THE MCO's have been given FREE REIGN in "absorbing" the HCBS waiver and how it is administrated/ implemented by respective MCO ... into their existing operational protocols.

Simply Put, when a provider is told that they have 6 months to meet the requirements of the MCO, by each of our MCO Account Representatives, or face the real possibility that we would not have our "tentative contract" extended..... LIGHTS AND ALARM BELLS GO OFF.

Simply put, the HCBS waiver IS NOT just another "PRODUCT" for MCO's manage. HCBS waivers and the "services" that are offered ARE NOT a just another "SERVICE" that an MCO has the authority to re-define or re-constitute into a "product" that fits into their pre-existing efficiencies and operational protocols. The 1915c HCBS waiver is an already defined service/program and is a self-contained package that MUST BE MANAGED as it is was created, written and approved by CMS.

I DON'T SAY THIS.... The U.S. Supreme Court, Civil Rights Law, Pennsylvania State Law(s), 1915c HCBS Federal Regulations that already exist ...just to name a few of the sources .... SAY SO!

The MCO's secured an agree to manage the HCBS waiver as it was written and approved ... ANY **"SUBSTANIVE CHANGE"** they (the MCO) make or interprets as within their authority to make ..... MUST first be vetted by the State and Approved by CMS **BEFORE** it can be enacted.... Why? Because the Federal regulations governing 1915c HCBS waiver and its funding.... says so

In exploring this issue I have pulled together what I believe to be ALL relevant, current and available State and Federal regulation, MCO agreements, bulletins and guidelines as they apply to the provision of 1915c HCBS waiver(s), specifically to the issue at hand ... clearly asserting that:

"HOME CARE AGENCIES/HOME CARE REGISTRIES
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To begin I have read the Final Agreement between the State/DHS/OLTL and the Three (3) MCO's as approved by CMS- Center for Medicaid Services regarding their respective MCO roles and responsibilities.

In this document it is made clear that:

1) **The State/DHS STILL must/retain OVERSIGHT** over, in this case, the MCO's and how they (the MCO's) **comply with their contracted responsibilities/function in the administration/management of the 1915c HCBS waiver and in their management of the "SERVICES" and "SERVICE PROVIDERS" services made available to each individual participant approved to receive these waiver services.**
2) That said, in exploring the contracted authorities to and of the MCO's, I do not think it requires a statement beyond saying that ..... The contracted entities, (the MCO's), in the provision of the CHC waiver and its "SERVICES" to participants/consumers, albeit revenue stream for the MCO's, that the "SERVICES" provided AS WRITTEN/DEFINED and the manner by which the service(s) and their delivery modalities... "SERVICE PROVIDERS" were /are defined/credentialed to provide said service(s)... MUST be done/provided so AS WRITTEN AND DEFINED AND APPROVED in the waiver and in COMPLIANCE with ALL State and Federal rules and regulations. Simply stated, the MCO's DO NOT have ANY authority to redefine, realign , re-constitute, re-interpret ANY SERVICE , ANY SERVICE PROVIDER or their respective SERVICE PROVISION pathways ..... **Without and until the "DEPT"... DHS and more importantly until CMS approves it in writing.**

CONCERNING FACTS and CURRENT REALITIES:

1- EFFECTIVE 1/1/2018 ... AS THIS NEW MCO CONSTRUCT IS /WAS/IS BEING ROLLED OUT... THE STATE/OLTL IN ESSENCE HAS/WILL SEIZE TO PERFORM REDUNDANT OVERSIGHT, SUPPORT AND MONITORING OF THE WAIVER(S) ... (Aging, Independence and Act 150/Attendant Care).

AFTER SPEAKING WITH QMET REPRESENTATIVES .... THE FORMER DHS/OLTL WAIVER COMPLIANCE WATCH DOGS..."THERE IS ZERO ACTIVITY / MONITORING OR A PLAN TO MONITOR ANY 1915C WAIVER COMPLIANCE ISSUE UNDER/THROUGH THE MCO CONSTRUCTS". **DISTURBINGLY ONLY AND UNLESS THE MCO BRINGS IT TO THE STATES ATTENTION.**

2- THE MCO'S ARE RIGHT NOW ISSUING OPERATIONAL DIRECTIVES AND MANDATES IN A CHAOTIC, CONFUSING MANNER TO PROVIDERS... THESE DICTUMS SHOULD BE OF GREAT CONCERN ... TO THE STATE.... BECAUSE THEY ARE INCONSISTANT WITH/ALTER/DEPART FROM WHAT AND HOW THE APPROVED WAIVER READS REGARDING "SERVICE DEFINITIONS", "SERVICE PROVIDER TYPES" AND THE MANNER BY/OF WHICH THE MCO CONSTRUCT SHOULD OPERATE AS STATED IN THE APPROVED WAIVER...

WHEN QUESTIONED, THE VARIOUS MCO ACCOUNT REPRESENTATIVES ARE VERY QUICK TO SAY ..."IF YOU WANT THE OPPORTUNITY TO BE A CONTRACTED PROVIDER AFTER THE INITIAL 6 MONTHS ... YOU NEED TO COMPLY WITH OUR INTERNAL OPERATIONAL PROTOCOLS". WHO SAID IT? ... EVERYONE ONE OF MY AGENCIES DESIGNATED PREPRESENTATIVE CONTACTS FROM ALL THREE (3) MCO'S , AS WELL AS THE HHA EXCHANGE. SUFFICE IT TO SAY... I HAVE HAD SEVERAL COMMUNICATION EXCHANGES. ANY PROVIDER WHO WAS TRYING TO OBTATIN ANY INFORMATION ABOUT THIS NEW MCO CONTRUCT FOUND OUT VERY QUICKLY THAT THERE WERE MANY QUESTIONS WITH LITTLE TO NO ANSWERS BEING GIVEN..... ESPECIALLY TROUGH THE SO CALLED TRAINING SESSIONS.

3- In the HHA Exchange Home Care Agencies/Home Care Registries **ARE HARD CODED/CATEGORIZED** as HOME HEALTH CARE AGENCIES. Surely the State id it's Due Diligence in determining/verifying the system the MCO's would use... But the truth of the matter is that Home Care Agencies/Home Care Registries as directly communicated to me through my contacts with our designated Account Representatives are" .... ARE THE SAME"... moreover that ..." the HHA Exchange is a HHA- Home HEALTH aide/HOME HEALTH CARE agency program".... "To specifically align HOME HEALTH CARE providers and SERVICES in a more efficient way for the MCO's to do their job". Do not take my word for it... do your own research.... Go the HHA Exchange.... Pull up the list of available HOME CARE PROVIDERS ... THAT provide PAS-PERSONAL ASSISTANT SERVICES.....
The LIST generated WILL include both Home Care Agencies/Home Care Registries AS WELL AS HOME HEALTH Care Providers.
OR better YET! Look up a LICENSED Home Care Provider by name, in the HHA Exchange Data base.... What you will see is that provider entity is CATEGORIZED/CLASSIFIED AS a HOME HEALTH Care Agency.... WHY? Because it's the only PROVIDER TYPE that they can be listed as.... In fact there is no reference or description of HOME CARE as a SERVICE TYPE anywhere.
Right now! There ARE Home HEALTH Care agencies providing the SERVICE of PAS-Personal Assistant Services.... Billing for and being paid for the provision of that service.

The purpose of this paper is to shed light on what the State of Pennsylvania stated in its waiver application (IT'S SERVICE PLAN) with CMS approval, ... Detailing the manner in which and by which the 1915c HCBS waiver and the services it offered WOULD BE provided to Participants/Consumers approved to receive HCBS waiver services.

4- PROBABLY THE MOST CONCERNING FACT IS THAT THIS MCO CONSTRUCT WAS INITIALY ROLLED OUT IN CENTERAL AND WESTERN PA... (January of 2018).... AND THAT GIVEN THAT THE SAME CHC WAIVER, THE SAME SERVICES AND SAME SERVICE PROVIDERS/DELIVERY MODELS WERE BEING USED IN THE SAME MCO /CHC WAIVER CONSTRUCT AS TODAY ... IT IS PERPLEXING THAT THE ISSUES CONTAINED IN THIS PAPER ...TRANSITIONG FROM THE EXACT SAME OLD SYSTEM TO THE EXACT SAME NEW SYSTEM... YET! NO ONE... NO PROVIDER... NO PARTICIPANT .... AT LEAST FROM OR IN WHAT Q&A AND TRANSITIONAL STATUS REPORTS AND UPDATES HAVE COMMUNICATED .... SURELY!!!! THIS ISSUE WOULD HAVE BEEN IDENTIFIED AND CORRECTED/ADDRESSED ALONG THE WAY .... IF APPROPRIATE OVERSIGHT WERE APPLIED.

5- Instead the various Systems (HCSIS and PROMISE) , Quality Management (QMET) albeit still active, have NO involvement with the MCO's or the HHA Exchange when asked who to go to if a provider has any questions or issues... they respond by saying "I DON'T KNOW" and direct you to the general contact number of that consumers chosen MCO.

IN ESSENCE THE STATE WENT "LIVE" WITH THE NEW MCO/HHA EXCHANGE CONSTRUCT WITH NO FALL BACK OR SAFETY NET FOR CONSUMERS AND/ OR PROVIDERS ADDRESS ANY ISSUES OR ASK ANY QUESTION.... OTHER THAN BY AND THROUGH CONTACTING THE RESPECTIVE MCO.... REGARDLESS IF THE ISSUE WAS SPECIFIC TO THE MCO OR THE HHA EXCHANGE.

ABOUT THE CHC WAIVER: WHAT DOES CMS GUIDANCE SAY:

The CHC Waiver as it was approved by CMS is CATEGORIZED as a "AMENDMENT" that Consolidated (3) three pre-existing OLTL HCBS waivers (INDEPENDENCE, ATTENDANT CARE AND AGING) INTO (1) ONE waiver...

That said, as an AMMENDMENT ... which in these situations COMBINES EXISTING WAIVERS .... AS DEFINED AND IS ARTICULATED BY CMS IN: Application for a 1915c Home and Community Based Support waiver: INSTRUCTIONS, TECHNICAL GUIDE and REVIEW CRITERIA (January 2015): on page 24,

It states:

Combining Waivers. Alternatively, a state may determine that it would be more efficient to combine two approved waivers that serve the same or very similar target populations. If both waivers expire on the same date, the combination of the two programs may be accomplished by submitting a renewal application for the waiver that would continue and allowing the other program to expire. The state should alert CMS when it plans to follow this course. In addition, when the two waivers cover different services, CMS may require the state to prepare and submit a transition plan if the effect of combining the waivers would be to reduce the services provided in one or both waivers. If the waivers have different expiration dates, the state should notify CMS that it intends to combine the two programs, and seek instructions.

Under the heading "Policies Concerning Amendments" page 26 it goes on to read:

Amendments to an approved waiver may be submitted at any time.... **unless the amendment includes changes that are substantive.** Per CFR 441.304, waiver amendments that include changes that are substantive may take effect only on or after the date of CMS approval.

Substantive changes include but are not limited to:

*Revisions to services available under the waiver including elimination or reduction of services or reduction in the scope, amount, and duration of any service;
***A change in the qualifications of service providers** (this includes a reduction of providers);
*Changes in rate methodology, or a constriction in the eligible population (i.e., a reduction in the number of persons served).
*Additional **examples of substantive changes include: consolidating waivers, adding services, and changes in performance measures/indicators.**
*Please note that changes in the quality system are substantive. For example adding or deleting sub-assurances or **adding or deleting reporting requirement**. In addition, please note that typically, in increase in the unduplicated number of participants is not considered to be a substantive change. However, when waiver actions include (or should include) a HCB settings transition plan, the action is considered to be substantive due to the transition plan. A retroactive effective date can be permitted for the purpose of increasing the unduplicated number of participants. The state is required to establish a public input process specifically for HCBS changes that are substantive in nature. **Substantive changes must be accompanied by information on how the state has assured smooth transitions and minimal**

adverse impact on individuals impacted by the change. When an amendment would have the effect of reducing the number of waiver participants, the state also should review CMS guidance in Olmstead Letter #4 (located in Attachment D to the instructions).

Clearly ALTERING OR RE-INTERPRETING OR RE-DEFINING ANY "SERVICE" or "SERVICE PROVIDER" delivery component TO PRESENT IN A MANNER THAT WAS NOT "AS APPROVEN AND WRITTEN ... COULD and often does, AS WARNED BY CMS in its Technical Guidelines, BE A SUBTANITIVE CHANGE AND FURTHER DESTROY the VERY RATIONALE /MANNER IN WHICH "WAIVERS AND THEIR WAIVER SERVICES" WERE CREATED AND SCRIPTED TO BE PROVIDED.

THE CHC WAIVER AS AN APPROVED WAIVER ESSENTIALLY OUTLINES A TRANSITIONAL PLAN FROM an OLD MODALITY TO A NEW MODALITY.... The CHC waiver is presented SIMILAR IN NATURE TO THAT OF An INDIVIDUAL SERVICE PLAN.... OR MORE TO THE POINT.... A GUIDE TO LEAD THE BEHAVIORS OF ALL PLAYERS IN HOW EACH FITS INTO AND FACILITATES PROCESSING THEIR RESPECTIVE SERVICES IN THE TRANSITION GOAL OF THE WAIVER....

ANY action of the State to RE-DEFINE or RE-INTERPRET let alone implement the provision of services in any manner "DIFFERENT" than that was expressly articulated in the waiver after it has been approved by CMS, without CMS approval.... let alone ... to be done ... BY A NON GOVERNMENTAL ENTITY contracted to perform the role and responsibilities, as a MCO, on behalf of the State's designated Lead Medicaid Agency could be viewed as a breach of its (the State's/DHS) responsibilities.

THIS HAS BEEN CALLED OUT BY CMS AND IN OLMSTEAD AND ITS DIRECT COMMUNICATIONS TO EACH STATE THROUGH WHAT HISTORICALLY REFFERED TO AS THE "OLMSTEAD LETTERS".... CAUTIONING ABOUT THE TRAPS OF "INSTITUTIONAL BIAS".

The most critical aspect of A SERVICE PLAN/BEHAVORAL PLAN (the 1915c HCBS waiver) is it's **SUBSTANTIVE CORE of SERVICE DEFINITIONS** and the consistency of/to which these SERVICE DEFINITIONS are UNDERSTOOD, constructed, defined as AND ADHERED to by all involved parties: the MCO's each consumer/participant and each provider EXECUTION/ implementation of the waiver plan the "services" afforded within the plan.

From Wikipedia,

A **plan** is typically any diagram or list of steps with details of timing and resources, used to achieve an objective to do something. It is commonly understood to be a set of intended actions through which one expects to achieve a goal.

The State MUST under stand that the "APPICATION" of/for 1915c HCBS waiver funding is a DETAILED DESCRIPTION/PLAN of how it will provide the services of HCBS to designated participants (Target Population).

EVERY KEY ELEMENT MUST BE DEFINED SO THAT ALL (EVERY) PLAYER UNDERSTANDS WHAT IS EXPECTED OF THEM IN THE EXECUTION TOWARDS MEETING THIS GOAL.... THE PROVISION OF THE "SERVICES" CONTAINED IN/OF THE 1915C HCBS WAIVER.

SERVICE DEFINITIONS

"Service Definitions" are defined as written in governing regulations, policies: specifically, Chapter 52 and 1101, Chapter 611, and Direct Care Worker Non-Skilled services in HCBS setting JOINT Clarification statement issued by DHS and the Dept. Health in November 2016 regarding the provision of HCBS waiver.

This is SPECIFICALLY addressed in APPENDIX C: PARTICIPANT SERVICES of the 1915c HCBS waiver: C-1: Summary of Services Covered

a. **Waiver Services Summary**. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

The State not only lists ALL "SERVICES" , the State also DEFINES THEM... **Specifically the "SERVICE" of Personal Assistance Service (PAS) . Page 82.**

This paper WILL NOT re-write what (PAS) are... you can read that for yourself, But I will direct you to the bottom of page 83 and top of page 84, where it reads : **Provider Specifications**: it reads:

NOTE: Provider Specifications addresses the TYPE OF Provider that CAN ... IS AUTHORIZED to provide the "SERVICE" of (PAS).

Provider Category	Provider TYPE TITLE
Agency	Home care Agency
Individual	Individual Support Service Worker

NOTE : THERE IS NO MENTION OF HOME HEALTH AGENCY, HOME HEALTH AIDE, ETC...

NOTE: The provider Credentialing/ Service Definition of: ***Individual Support Service Worker reads:***

- Support Service workers **must**:
- Comply with 55 PA Code 1101 and have a signed Medicaid waiver **provider agreement;**
- Comply with Department standards, regulations, policies and procedures relating to provider qualifications, including 55 PA Code Chapter 52;

HEALTH CARE FACILITIES ACT - LICENSURE OF HOME CARE AGENCIES AND HOME CARE REGISTRIES, CONSUMER PROTECTIONS, INSPECTIONS AND PLANS OF CORRECTION AND APPLICABILITY OF ACT

Act of Jul. 7, 2006, P.L. 334, No. 69

DEFINED:

Governing Regulations for Home Care Agencies: Chapter 611 HOME CARE AGENCIES/HOME CARE REGISTRIES Defines:

Home Care Agencies are: An Organization, **EXCLUSIVE of home HEALTH care agencies** that arrange, or schedules employees to provide or perform ADL's /IADL's **or companionship services or specialized care** on an hourly, shift or continual basis to a consumer **in the consumer's place of residence**.... The term (HOME CARE AGENCY) SHALL NOT include DME providers or volunteer providers. ... **"As directed by the consumer".**

NOTE: The Term "EXCLUSIVE", as stated/used as articulated in the Definition of Home Care Agency of this document, is defined by Webster's dictionary as follows:

1) **Restricted or limited to the person, group, or area concerned.**

2) **Excluding others from participation**

To add even more clarity to this issue DHS and the STATE issued a joint clarification statement; on November 14th 2016 regarding the provision of DIRECT CARE WORKER NON SKILLED Services in HCBS settings. http://www.paproviders.org/wp-content/uploads/2017/02/Policy-Clarification.pdf

Home Care Registries are An Organization or business entity or part thereof that supplies, arranges, or refers independent contractors to **provide ADL/IADL's or specialized care in the consumers place of residence.... "As directed by the consumer"**

Governing Regulations for Home Health Care Agencies: Chapter 601 HOME HEALTH CARE AGENCIES Defines:

Home Health Care Agencies as: An Organization or part thereof staffed and **equipped to provide nursing and at least one (1) therapeutic service to persons who are disabled, aged, injured or sick in their place of residence. The agency may also provide other HEALTH related services to protect and maintain person(s) in their own home...**

Side Note:

This clarification Statement was a by-product of a more comprehensive issue being worked through as referenced in the "Pennsylvania Long Term Care Commission Final Report (2014). Again understanding that the Joint clarification Policy Statement written in November of 2016. SOME 4 years BEFORE the implementation of the CHC Waiver and executing the MCO construct, the policy statement ended by saying" Pennsylvania is moving to Community Health Choices (CHC), a Medicaid managed care system for induvial with physical LTSS needs and individuals dually eligible for Medicaid and Medicare. This policy aligns with the goals of CHC and will further the Commonwealths efforts to encourage LTSS in HCBS settings.

ISSUE:

The Administration is issuing a policy that clarifies they TYPES of non-skilled services/activities that can be performed in a consumers place of residence or other independent living environment NY PERSONAL ASSISTANTS, direct Care workers, nursemaids or other house hold aids of any type (Collectively, DCW's) in ALL home and community Based services (HCBS) settings.

This services/activities fall under the Dept. of Health (DOH) Home Care Agency Regulations governing home care services as directed by an individual in a home or independent living environment, Dept. of Human services (DHS) regulations and HCBS waiver programs and the State funded Act 150 program and are EXEMPT from the licensure requirements under the Professional Nursing Law and Practical Nursing Law as "Home Care".

Background:

In 2015, Disability Rights Pennsylvania (DRP) contacted DHS and DOH to discuss potential litigation concerning a conflict in the agencies implementation and interpretation of separate DHS and DOH regulations and policies impacting individuals with disabilities who received funding through DHS/HCBS program. DRP brought the issue to the attention of DHS and DOH after DOH informed a Home Care Agency that performance of clean intermittent catheterizations by DCW's was not in the SCOPE of practice for a DCW or Home HEALTH aide or Nurse Aide.

DHS/DOH began working with the Dept. of State (DOS) to explore options to clarify the TYPES of non-Skilled SERVICES /activities that can be performed by DCW's for individuals with disabilities in ALL HCBS settings.....

This JOINT statement goes on to read:

Under Act 69 of 2006 (PL 334 no. 69) which AMENDS the Healthcare Facilities Act (HCFA), Home Care services are provided by Home Care Agencies and by contractors listed in Home Care Registries.....

Home care Agencies /Home Care Registries are regulated by DOH pursuant to Chapter 611... as defined above ....

In other words, to a lay person, this JOINT statement means that **Home HEALTH Care agencies CAN NOT** participate in the provision or provide or perform ADL's/IADL's or companionship services or specialized care on an hourly, shift or continual basis to a consumer in the consumer's place of residence.... **IF THOSE SERVICES ARE BEING PAID FROM HCBS funding....** BECAUSE THEY (Home HEALTH CARE Agencies) ARE NOT authorized to provide the SERVICE of PAS ... which as defined in APPENDIX C of the CHC waiver.

Moreover a Health Care professional (Aide, Nurse Etc....) **CAN** provide such services as defined under APPENDIX C of the waiver.... **but only through and limited by the SCOPE of SERVICE of "RESPITE".**

Further .... Pursuant to **The Professional Nursing Law.... this does not prohibit "home care"** of the sick by friends, domestic servants, nursemaids and companions or household aides of any type, **so long as such persons do not represent or hold themselves out to be licensed nurses, licensed registered nurses, or registered nurses; or use in connections with their names, any designation tending to imply they are licensed to practice under the provisions of this act..." (63 P.S, S 214(1)). ....**

Meaning representing one self as being assigned, offered, referred through or under the organizational Banner of an organization representing itself to be a HOME HEALTH CARE provider.... IS PROHIBITED !!!!

Likewise, the Practical Nurse Law does not prohibit "home care of the sick by friends, domestic servants, nursemaids and companions or household aids of any type so long as such persons do not represent or hold themselves out to be practical nurses or use in connection with their names any designation tending to imply that they are licensed to practice under the provisions of this act." (63 P.S. S 653(1)).

That said, HOME HEALTH CARE AGENCIES as defined under Appendix C : CAN provide the "SERVICE" of RESPITE CARE (as Defined) within the waiver APPENDIX C : Provider Specifications.

The "SERVICE" DEFINITION of the "SERVICE" of RESPITE : reads in part:

Service Definition (Scope): Respite services are provided to support individuals on a short-term basis (UP TO 24 days/YEAR) due to the absence or need for relief of unpaid caregivers normally providing care. Federal and state financial participation through the waivers is limited to:

1) Services provided for individuals in their own home, or the home of relative, friend, or other family, or
2) Services provided in a Medicaid certified Nursing Facility. Room and board costs associated with Respite Services that are provided in a facility approved (licensed or accredited) by the state that is not a private residence are reimbursable. Respite Services furnished in a participant's home are provided in quarter hour units. Respite Services may also be provided in a long-term care facility on a per diem basis. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.

WHO CAN PROVIDE THE "SERVICE" OF RESPITE ; PROVIDER SPECIFICATIONS:

Provider Category	Provider TYPE Title
Agency	**Home Care Agency**
Individual	Individual Respite Worker
Agency	Medicaid Certified Nursing Facilit
Agency	**Home Health Agency**

Again to maintain clarity, HOME HEALTH AGENCIES can offer the "SERVICE" of HOME HEALTH AIDE: But the "SERVICE" DEFINITION of a Home Health Aide reads:

Service Definition (Scope): Home Health Aide services are direct services prescribed by a physician in addition to any services furnished under the State Plan that are necessary, as specified by the service plan, to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The physician's order must be obtained every sixty (60) days for continuation of service. The home health aide provider is responsible for reporting, to the ordering physician and Service Coordinator, changes in the participant's status that take place after the physician's order, but prior to the reauthorization of the service, if the change should result in a change in the level of Nursing services authorized in the service plan. **Home Health Aide services are provided by a home health aide who is supervised by a registered nurse. The registered nurse supervisor must reassess the participant's situation in accordance with 55 PA Code Chapter 1249, §1249.54.** Home Health Aide activities include, personal care, performing simple measurements and tests to monitor a participant's medical condition, assisting with ambulation, assisting with other medical equipment and assisting with exercises taught by a registered nurse, licensed practical nurse or licensed physical therapist. The service provider must maintain documentation in accordance with Department requirements. The documentation must be available to the Service Coordinator for monitoring at all times on an ongoing basis. The Service Coordinator will monitor on a quarterly basis to see if the objectives and outcomes are being met. Specify applicable (if any) limits on the amount, frequency, or duration of this service: Home Health Aide services may only be funded through the waiver when the services are not covered by the State Plan, Medicare or private insurance. This may be because the State Plan, Medicare or private insurance limitations have been reached, or the service is not covered under the State Plan, Medicare or private insurance.

This exercise may appear to be trivial, but the waiver had to be written and presented according to 1915c HCBS Application Technical Guide instructions and articulate clear methodology of its implementation and delivery to all "SERVICES" respective of each AUTHORIZED Provider Type to recipients approved to receive HCBS waiver services, as well as provide clear guidance to respective providers as to who can provide each specified waiver "service".

NOTE: THERE IS NO STATEMENT MADE THAT A HOME HEALTH CARE AGENCY IS AUTHORIZED TO PROVIDE THE PRESCRIBED "SERVICE" OF PAS - PERSONAL ASSISTANCE SERVICES (PAS) AS DEFINED UNDER the 1915C HCBS WAIVER (CHC waiver) APPENDIX C: Participant Services.

A PROVIDER OF PAS MUST BE EITHER A HOME CARE AGENCY/HOME CARE REGISTRY OR A PROPERLY LICENSED INDIVIDUAL ENTITY.

COMPARING THE LICENSURE OF

HOME CARE AGENCIES/HOME CARE REGISTRIES TO

THAT OF A HOME HEALTH CARE AGENCY

Home Care Agency/Home Care Registry is licensed by the PA Department of Health, per 28 PA Code Chapter 611 (Home Care Agencies and Home Care Registries):

CHAPTER 611 - HOME CARE AGENCIES AND HOME CARE REGISTRIES Reads in part:

(a) **This chapter applies to home care agencies, home care registries and to entities that meet both definitions, profit or nonprofit, operated in this Commonwealth**, as defined in this chapter.

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

HOME HEALTH CARE AGENCY is defined under the waiver APPENDIX C: as an entity with the Provider Qualifications License through the PA Department of Health, per 28 PA Code, Part IV, Health Facilities, Subpart G. **Chapter 601 and Subpart A. Chapter 51. Certificate** (specify):

CHAPTER 601: HOME HEALTH CARE AGENCIES reads;

Home health care agency—An organization or part thereof staffed and equipped to provide skilled nursing and at least one therapeutic service—physical therapy, occupational therapy, speech pathology, medical social services or home health aides—to disabled, aged, injured or sick persons on a part-time or intermittent basis in

their place of residence. The term includes an agency that also provides other health-related services to protect and maintain persons in their own homes.

Further **In Chapter 52:**

Personal Assistance Services (PAS) is defined : Services aimed at assisting the participant to complete **ADLs and IADLs** that would be performed independently if the participant did not have a disability.

In Chapter 611: Home Care Agencies and Home Care Registries

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

Home care services—The term encompasses the following activities:

(i) **Personal care.**

(ii) **Assistance with instrumental activities of daily living.**

(iii) Companionship services.

(iv) Respite care.

(v) Specialized care.

IN CONCLUSION:

In a quick review all of the presented regulatory and policy , both State and Federal, that clearly articulates this position papers assertion that "HOME CARE AGENCIES/HOME CARE REGISTRIES ARE NOT HOME HEALTH CARE AGENCIES" as stated below. Hopefully, and preferably, DHS will take whatever proactive and retroactive actions necessary to more accurately align MCO/HHA Exchange in their presumptive interpretation of their respective function and authorities as they relate to the management of Pennsylvania's 1915c HCBS waiver ... called CHC-Community Health Choices Waiver.

The Waiver as written is the TOOL by which CMS will use in auditing Pennsylvania's compliance to the administration and management of the waiver (approved as written). The waiver does not give any entity , The State or as in this case, the MCO's/HHA Exchange any blanket authority to make whatever changes without first seeking and gaining the State's and more importantly CMS approval to do so, BEFORE, the execution of ANY action.

As outlined in this position paper:

1- We discussing Home and Community Based Support (HCBS) Waivers. Specifically as defined in the Community Health Choices Home and Community Based Supports waiver that went into effect 1/1/2018.
2- There are (3) PLANS or MCO's contracted to facilitate the provision of the CHC waiver and its services .
3- We have reviewed the Function/Scope of these MCO's- Managed Care Organizations as to their "ADMINISTOR /MANAGEMENT " role in the provision of HCBS waiver services to a "TARGETED POPULATION" of individuals, approved by the State of Pennsylvania as eligible to receive HCBS waiver SERVICES (AS DEFINED) provided to them through and under DEFINED SERVICE Provider entities.
4- **We have discussed the GENERAL Nature of the STATE/MCO Agreement**: The CHC-MCO must **provide for all Covered Services** and related services to Participants through Providers in accordance with this Agreement in the following zones on the following schedule: the Southwest Zone – January 1, 2018; the Southeast Zone –July 1, 2018; and the Lehigh Capital, Northwest, and Northeast Zones – January 1, 2019.
5- **Specific to Medicare** The CHC-MCO must **operate a CMS-approved D-SNP** as provided in this Agreement in each zone. For the SW Zone, the D-SNP must be in process in July 2017 to have a D-SNP operating and must have a CMS-approved D-SNP operating by January 1, 2018. For other zones, the CHC-MCO must have a DSNP operating at the time of implementation for the zone.
6- **HOME CARE AGENCIES/HOME CARE REGISTRIES** are licensed through/under PA Dept. of Health pursuant to Chapter 611 regulations
7- **HOME HEALTH CARE AGENCIES** are licensed through/under PA Dept. of Health regulations pursuant to Chapter 601 regulations
8- Home and Community Based Support Waiver (CHC) services are /can only be provided under and in approved HCBS settings as approved by CMS effective 1/1/2018.
9- **The services that each of these PLANS /MCO's MUST Provide/Administer are articulated in APPENDIX C –Service Specifications of the CHC HCBS waiver**.
10- Of these stated "SERVICES" as written in APPENDIX C : 1) EACH "SERVICE TYPE" IS CLEARLY DEFINED, 2) Each "SERVICE PROVIDER"- TYPE is: Clearly defined, 3) the **SCOPE** of Each SERVICE, and SERVICE PROVIDER is clearly defined, 4) The TYPE of Providers that can provide the specific "SERVICE" are clearly defined.
11- The SERVICE at issue in this discussion is that of PAS-Personal Assistant Services.
12- As with every waiver, Specific SCOPES and Roles define the TYPE of "SERVICE PROVIDER" Service terms MUST BE clearly defined (SCOPE)in order to structure a consistent operational environment and service delivery mechanism.
13- The Regulatory documents that are inclusive in this discussion are: Health Facilities Care Act, Act 69, the Dept. of Health Chapters 611 and 601. OLTL's Chapters 1101 and Chapter 52, various OLTL Bulletins (as Identified) as well as the approved CHC waiver.
14- This paper uses Webster's Dictionary definitions (as a neutral source) in defining a MCO – Managed Care Organization: defined: as **a company** (as an HMO or PPO) **offering health-care plans with cost controls using managed care**. And

15- **Managed Care** is defined as a: **a system of healthcare in which patients agree to visit only certain doctors and hospitals, and in which the cost of treatment is monitored by a managing company and Health·care : as the organized provision of medical care to individuals by a community of Health Care Workers**

16- Collectively, as these documents articulate, workers that provide the service of PAS are referred to as "DCW"s (DIRECT CARE WORKERS). This term/definition refers EXCLUSIVELY in/to the provision of HCBS waiver services to consumers in their own home as defined as a HCBS waiver settings.... And

17- The HCBS setting and the provision of the service of PAS through HCBS waiver services (as defined) falls under the Dept. of Health Chapter 611 – Home Care Agency/Home Care Registries regulations and are as such EXEMPT from licensure requirements under the Professional Nursing Law and Practical Nurse Law as Home Care.

18- WE also discussed that In 2015, Disability Rights Pennsylvania ("DRP") contacted DHS and DOH to discuss potential litigation concerning a conflict in the agencies' implementation and interpretation of separate DHS and DOH regulations and policies impacting individuals with disabilities who received funding **through DHS' HCBS program**.

19- PA Code 55 Chapter 52 : § 52.2. **Scope**.
This chapter sets forth the regulations which apply to providers applying to participate and render MA-funded waiver services under the Federally-approved Aging, Attendant Care, COMMCARE, Independence and OBRA Home and Community-Based Service waivers or the Act 150 program.

This Paper, using erupts from cited policy documents narrates that anyone seeking to practice professional nursing or practical nursing must obtain a license to do so. The practice of professional nursing is "[d]iagnosing and treating human responses to actual or potential **health problems** through such services as case findings, 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." (49 Pa. Code 5 21,1). The practice of practical nursing is "[t]he performance of selected nursing acts in the care of the ill, injured or infirm under the direction of a licensed professional nurse, a licensed physician or a licensed dentist which do not require the specialized skill, judgment and knowledge required in professional nursing." (49 Pa. Code S 21..1.4l). The DOS regulates nurses. (63 P. S. 55 2ll through 225.5, and 65l through 667; and 49 Pa. Code Chapter 2L).

Further, The Professional Nursing Law does not prohibit "home care of the sick by friends, domestic servants, nursemaids and companions or household aides of any type, **so long as such persons do not represent or hold themselves out to be licensed nurses, licensed registered nurses, or registered nurses; or use in connections with their names, any designation tending to imply they are licensed to practice under the provisions of this act..." (63 P.S, S 214(1)). Likewise, the Practical Nurse Law does not prohibit "home care of the sick by friends, domestic servants, nursemaids and companions or household aids of any type Under the heading " Home And Community Based Services"- DHS... So long as persons or entities DO NOT represent or hold themselves out to be licensed nurses ,licensed**

registered nurses or use in connection with their names any designation tending to imply they are licensed (63 P.S. 653(1)).

DHS delivers HCBS through Medicaid funded or state funded programs. HCBS provide support services that enable a person to remain in a community setting (including the consumers own home) rather than in or being admitted in to a institutional setting.....

In Clarification Policy document final statement, again written in 2016. Reads:

Pennsylvania is moving to Community HealthChoices (CHC), a Medicaid managed care system for individuals with physical LTSS needs and individuals dually eligible for Medicaid and Medicare.....

An argument proposing that because these "services" (those of PAS) are deemed "Medically Necessary" are medical (Health related) and therefore CAN NOT "Exclude" Home Health Care Agencies.... Is at best show the complete "Institutional Bias" of that person and or entity.

One only needs to read the definition as it is written in Chapter 1101... which reads : "Medically Necessary" / " Medically Needy" (the ONLY regulation that defines this term)

Medically necessary—A service, item, procedure or level of care that is:

(i) Compensable under the MA Program.

(ii) Necessary to the proper treatment or management of an illness, injury or disability.

(iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.

Medically needy—A term used to refer to aged, blind or disabled individuals or families and children who are otherwise eligible for Medicaid and whose income and resources are above the limits prescribed for the categorically needy but are within limits set under the Medicaid State Plan.

In Chapter 611 the ONLY related term reads:

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

As you can see, the definition DOES NOT implicitly or explicitly imply that the "SERVICE" is/be medical in nature... But the waiver and supporting regulatory SERVICE DEFINITIONS do say that PAS IS NOT A HEALTH CARE SERVICE. FURTHER THAT THE SERVICE OF PAS CAN ONLY BE PROVIDED THROUGH HOME CARE AGENCIES/HOME CARE REGISTRIES as defined/licensed,

That said, reviewing: Chapter 52 - LONG-TERM LIVING HOME AND COMMUNITY-BASED SERVICES, Chapter 1101 - GENERAL PROVISIONS, Chapter 1101 reads;

§ 1101.11. General provisions.

(a) **Scope**. This chapter sets forth the MA regulations and policies which apply to providers. **Regulations specific to each type of provider** are located in the separate chapters relating to each provider type.

In Chapter 611: § 611.1. **Legal base**.

(c) The purpose of this chapter is to protect and promote the public health and welfare through the establishment and enforcement of regulations setting minimum standards for the operation of home care agencies and home care registries. **The standards are intended by the Department to assure safe, adequate and efficient home care agencies and home care registries, and to promote the health, safety and adequate care of the consumers of services provided by home care agencies and home care registries.**

Why! Is this a huge issue. Simply put and consistent with CMS direction articulates.... IS that HCBS waivers and the services it provides should emphasize **WHAT THE SERVICES ARE** and not what the services ARE NOT. Furthermore,:

1- PROVIDERS LICENSED/DEFINED BY THE STATE AS "HOME CARE" PROVIDERS ARE BEING RE-CATEGORIZED/RE- DEFINED .... THROUGHOUT EACH RESPECTIVE MCO/HHA EXCHANGE SYSTEM... AS "HOME HEALTH CARE" PROVIDERS.
2- AND, that by doing so, a participants Support/ Service Coordinator (SC) access to and ability in LOCATING .... QUALIFIED and AUTHORIZED Potential (SERVICE PROVIDERS) .... AUTHORIZED to provide the "SERVICE" of PAS-Personal Assistant Service(s) (as defined and regulated):
   (A) The SC can only generate WRONGLY GROUPED PROVIDER TYPES (Those of both Home Care Agencies/Home Care Registries TOGETHER WITH the "SERVICE PROVIDER TYPE" (AS DEFINED) of Home Health care Agencies....THAT ARE NOT AUTHURIZED TO PROVIDE THE "SERVICE" OF PAS. (AS DEFINED).
   (B) The impact of this ISSUE ..... besides being MIS LEADING to the participant... is that it is clearly NOT IN COMPLIANCE WITH THE APPROVED 1915c HCBS/CHC WAIVER as the blue print for how the waiver and its available services and service providers are to be used.
   (C) Moreover it violates every fundamental component and rationale for the waiver.

In exploring the governing regulations, laws, statutes both state and federal as well as the CHC waiver itself, this exercise highlights a systemic problem that still to this day, through presumptive "INSTITUTIONAL BIAS" or ignorance or directed by the societal changes that erase the once presumed validity of many facility providers that This population of individuals need to be taken care of rather than empowered to direct their own lives with greater independence.

The MANDATE stated in each providers PROVIDER AGREEMENT ... to advocate for the consumer/participant... Moreover give/make available accurate choice options so that consumer/participant can exercise their RIGHT in making informed choices is so closely intertwined in the overarching philosophy of HCBS waivers and consumer direction it is inconceivable to imagine any

other interpretation if only given the fact that HCBS waivers and its services, as defined in this CHC waiver, are to support individuals IN THEIR OWN HOMES and not in inpatient facilities.

Albeit WARNED throughout the CMS 1915c HCBS waiver application process ... by failing to CHECK ITSELF regarding potential misrepresentations the State of Pennsylvania has allowed the approved HCBS waiver to be SUBSTANTIVELY ALTERED by the MCO (WILLING OR NOT) ... it is the States responsibility (At the end of the day) to oversee the MCO's to ensure HCBS Waiver administration/management is incompliance with regulation, but moreover in the manner that it, (the CHC Waiver) was approved by CMS.

By allowing the COMBINING of: 1) The TERMS: Home Care Agencies with that of HOME HEALTH Care Agencies ... THE MCO's are falsely representing... down right misleading ... each consumer by implying that the two DIFFERENT TYPES OF PROVIDERS are the same TYPE OF PROVIDER. 2) This misleading/ MISREPRESENTATION wrongly suggests to each and every consumer/participant TO THINK THAT THE "SERVICE" , ESPECIALLY THAT OF (PAS), as defined in the waiver IS SOMETHING THAT IS NOT somehow an individual right to direct through their "Employer Authorities". .. because it is a "medical service". ... is NOT TRUE on so many levels.

This SUBSTANTIVE change if left unchecked could very easily be mutated in/for every other "SERVICE" or any other "TYPE" of provider) ... simply because of established internal efficiencies ... operational protocols... of the MCO's and/or of the HHA Exchange... makes it convenient .

The State/OLTL has not only completely dropping of the ball, it has allowed fundamental protections of every Pennsylvanian's protected Civil Rights.

Although it was probably the right path of the State to outsource... contract with MCO entities in the manage and provision of HCBS waiver and its "services".... BUT it is imperative that the MCO's and the HHA Exchange understand that by seeking out and being awarded the contract.... That in doing so, the MCO's and the HHA Exchange MUST understand that they are "STATE ACTORS" in facilitating a already heavily regulated and clearly articulated packaged service... that requires NO RE-DEFINING. That they must mange the waiver and its "services" as approved by CMS.

NOTE: I offer the following link for your review as of 4/1/2019: WARNING : IT'S A MESS!!!!

https://www.upmchealthplan.com/find/#hospital/home&community

The back story is that a SC forwarded this to me and stated that this LINK was to be used in facilitating their function as the SC, in assisting participants to select available providers in their area.

What you will experience is that given the "SERVICE" (That of Persona Assistance Service (PAS)). Is that a list of PROVIDERS will be given based on the address of the consumer. This list includes EVERY TYPE OF PROVIDER.., Home Modification, Home Deliver Meals, etc...

The consumer, in performing their due diligence in trying to ascertain the "TYPE" of provider for each service as identified in their Individualized service plan... they must "click on" a Providers Profile to view what that provider can do as well as all other information, i.e., (counties served) .

Here is where it goes wrong, OF THOSE PROVIDERS LISTED, ALL PROVIDERS THAT ARE UNTHORIZED (AT LEAST BY HHA Exchange) to deliver the service of PAS.... THEY ARE ALL LISTED AS HOME HEALTH CARE AGENCIES.

As of this date, my agency, albeit properly licensed (since 2010) as a Home Care Agency/ Home Care Registry under the Dept. of Health.... It continues to be WRONGLY re-categorized (even after numerus inquiries and resubmissions of our license to both the MCO's and the HHA Exchange)... as a HOME HEALTH CARE Agency within both the HHA Exchange and more disturbingly within the respective MCO's provider Data Base.

The HHA Exchange representative(s) I have spoken to... and there have been several.... All state that each MCO has created their own portals and functionalities... I must discuss this with them. ODDLY but not surprisingly , when I contact our MCO representative they either say "I will Look Into It." OR "It Really DOES NOT MATTER!"

Again, according to the SERVICE SPECIFICATIONS (APPENDIX C of the waiver) listed in the approved waiver, the designated PROVIDER TYPES that can /ARE AUTHORIZED to provide the "SERVICE" of PAS are:

Provider Category	**Provider Type Title**
Agency	**Home Care Agency**
Individual	**Individual Support Service Worker**

This exercise may appear to innocuous but the waiver had to be written and presented according to 1915c HCBS application Technical Guide instructions and articulate clear methodology of its implementation and delivery to each approved waiver service offered through that waiver, as well as provide clear credentialing and licensing guidance to the providers who are licensed to provide the stated waiver service.

THERE IS NO STATEMENT MADE THAT A HOME <u>HEALTH CARE</u> AGENCY IS AUTHORIZED TO PROVIDE THE PRESCRIBED SERVICE OF PERSONAL ASSISTANCE SERVICES (PAS) AS DEFINED UNDER 1915C HCBS WAIVERS / (CHC waiver).

A PROVIDER OF PAS MUST BE EITHER A HOME CARE AGENCY/HOME CARE REGISTRY OR <u>A PROPERLY LICENSED</u> INDIVIDUAL ENTITY.

Why DOES IT MATTER? Lets say you visit your Doctor…. During that visit or examination it is discovered that you need to be seen by a CARDIOLIGIST…. Your Doctor gives you a list of SPECIALISTS in your area… you notice that ALL of the DOCTORS listed are Medical Doctors (MD's). BUT! not thinking that your Doctor just provided you with a list of EVERY SPECIALIST in your area…. you call to set up an appointment with one of the Doctors listed….. only to find out at the appointment that the Doctor, ALBEIT is a SPECIALIST,… is a Medical Doctor (MD) that specializes in PEDIATRY.