How Participants Enrolled in Community HealthChoices Can Access Assistive Technology (AT)

Most Pennsylvanians with disabilities and seniors who are eligible, or already receive, support services from the Department of Human Services, Office of Long-Term Living, are transitioning into a new Medicaid managed care program called Community HealthChoices. This includes participants who are currently enrolled in the Aging, Attendant Care, Independence and CommCare waivers. People who are "dual eligible" – meaning they receive Medicaid and Medicare services – are also transitioning into Community HealthChoices. Participants who are enrolled in the Act 150 Attendant Care and not "dual eligible" and OBRA waivers who are not nursing facility, clinically eligible are excluded from this program. For general information about eligibility for waiver standards, go to Pennsylvania Health Law Project's website, www.phlp.org, and click on Resources and Publications.

Pennsylvanians who participate in the new Community HealthChoices (CHC) managed care program and need Assistive Technology (AT) will get the AT they need from the CHC plan in which they are enrolled. AT devices, however, may be covered by one or more source(s) of coverage and under one or more covered service(s). This may cause confusion for Participants and CHC – Managed Care Organizations (CHC-MCOs). This factsheet and appendix outline how different AT devices may be covered and, we hope, will help Participants advocate for getting the AT devices they need approved.

> *Note: Throughout this document, "Participant" refers to the individual with a disability or older Pennsylvanian who is enrolled in the Community HealthChoices (CHC) Waiver program.*

Assistive technology (AT) is any device that helps a person with a disability achieve a more independent and productive life. As defined under the federal Assistive Technology Act, AT is "any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain or improve functional capabilities of individuals with disabilities." Examples of AT devices include items such as:

1) Adapted vehicles;
2) Computers, iPads, and tablet software and hardware;
3) Stair glides;
4) Hearing aids and other devices for people who are Deaf/Hard of Hearing;
5) Home modifications (ramps, roll-in showers, lowered counter tops);
6) Scooters and wheelchairs;
7) Seat lift chairs; and,
8) Safety and security devices.

AT service means any service that directly assists an individual with a disability in the selection, acquisition, maintenance or use of an assistive technology device. An AT service includes: evaluation, selecting, designing, customizing, adapting, applying, maintaining, repairing, replacing, and training on the use of the device.

Useful Resource

Pennsylvania Assistive Technology Foundation (PATF) is a statewide non-profit organization that can provide information about assistive technology funding resources to individuals with disabilities, seniors and their families. PATF can also provide no-interest or low-interest loans (with no fees) for the

purchase of assistive technology for components of AT that CHC doesn't cover (such as the chassis for a vehicle, home modifications that extend outside the original footprint of the home.) PATF helps Pennsylvanians of all ages, all income levels and all disability diagnoses and health conditions. For more information, go to PATF's website, www.patf.us, or call 888-744-1938.

Medicare

Medicare covers some AT devices. CHC is a Medicaid program (or, as often referred to in Pennsylvania, a Medical Assistance (MA) program) not a Medicare program and, therefore, CHC does not change what Medicare covers nor does it change a person's Medicare plan. Each Participant's CHC plan, however, has an obligation to provide comprehensive coordination with her Medicare plan. Accordingly, while the Medicare coverage of AT devices is no different for a person enrolled in CHC, access to Medicare coverage of AT should be improved through the CHC plan's involvement in facilitating access to the devices because Service Coordinators are required to coordinate Medicare services for CHC Participants.

> *Important: While CHC Participants who have Medicare are not required to have a Primary Care Physician (PCP) that participates in the CHC program and can continue to see the PCP they have been seeing through their Medicare, we recommend making sure the PCP understands all the coverage rules and procedures of the CHC program. Additionally, while it is not required that someone picks a PCP who participates in their CHC network, picking a CHC-MCO that already includes the Participant's PCP would best ensure that the PCP is equipped to work within both the Medicare and the CHC-MCO coverage rules. To learn which plan the current provider (the PCP) is contracted with, use the provider directory located at www.enrollchc.com, or you can call the Independent Enrollment Broker toll free (844) 824-3655 or (833) 254-0690 (TTY).*

Medicaid

The Medicaid (also referred to as Medical Assistance) State Plan covers some AT devices. The CHC program makes no changes to what is covered under the Medicaid State Plan. For example, those items that fall under Durable Medical Equipment (DME) and Medical Supplies will continue to be covered services. All three CHC-MCOs are required to cover the Medicaid State Plan AT devices. For some who have been in Medicaid Fee-For-Service and are used to getting coverage using their ACCESS card, enrollment into CHC will present a different way of getting their covered services since it is Medicaid Managed Care and not Medicaid Fee-For-Service. CHC enrollment will mean requests for devices will be submitted to the managed care plan instead of Pennsylvania's Department of Human Services (DHS).

Medicaid Home and Community-Based Services (HCBS) Waiver

Just as AT has been covered through some of the DHS Home and Community-Based Services (HCBS) Waiver programs in the past, AT will be available through the CHC Waiver for persons enrolled in CHC. This is a new HCBS Waiver for the CHC program. In it, AT devices are covered through a service titled "Assistive Technology" as well as through four other separately titled and defined services. AT devices may be available through the services titled: 1) Assistive Technology, 2) Durable Medical Equipment (DME), 3) Home Adaptations, 4) Specialized Medical Equipment and Supplies, and 5) Vehicle Modifications. *See the attached chart for complete definitions of each of these services.*

How to Request Assistive Technology?

Requests for AT will be directed to the Participant's service coordinator. Participants may mention their need or desire for AT during their periodic comprehensive assessments or person-centered planning

meetings. Participants may also request AT from their service coordinator at any time. The requested AT must be included in the Participant's person-centered service plan (PCSP) to be funded. If the item is one that Medicare might cover, the CHC-MCO must assist the Participant in pursuing coverage through her Medicare plan. If a Participant has other coverage she may have to request the AT through primary insurance first, depending on the item and whether it is something that Medicare or private insurance is likely to cover.

Important Note: Keep all denial notices. There may be several levels of appeal for a single AT device under the primary insurance plans. It is important to hold onto all the letters from the insurers denying coverage for AT because the CHC-MCO may ask to see the denial letters. See the section below on How to Get Help if Your Request Is Denied.

Who Recommends or Prescribes AT?

- Medicare Durable Medical Equipment (DME): Physician or other Primary Care Physician (PCP).
- Medicaid Durable Medical Equipment (DME): Physician or certain authorized non-physician practitioners (NPPs) document the occurrence of a face-to-face encounter with the Medicaid eligible beneficiary within reasonable timeframes. NPPs are Physician Assistants (PAs), Certified Registered Nurse Practitioners (CRNPs), Certified Nurse Midwives (CNMs) and Clinical Nurse Specialists (CNSs).
- Assistive Technology: Permissible Prescriber: AT devices must be recommended by an independent evaluator or by a physician with a physician's prescription. iPads, Amazon Echo/Alexa, and other forms of smart devices are reimbursable examples of electronic devices within the category of Assistive Technology.
- Home Adaptations: Permissible Prescriber: This service does not include, but requires, an independent evaluation that could be provided by another service. Depending on the type of adaptation, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech, hearing and language therapist; or physical therapist who meets all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Home adaptations must be obtained at the lowest cost and additional requirements apply in rented homes.
- Specialized Medical Equipment and Supplies: Permissible Prescriber: Requires an independent evaluation and a physician's prescription (a physician evaluation for hearing aids from a physician certified by the American Board of Otolaryngology (ear, nose, and throat physician.)) The independent evaluation may be conducted by an occupational therapist; a speech, hearing or language therapist; or physical therapist who meets all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through one of the following services offered through the waiver: physical therapy, occupational therapy, or speech therapy, or the State Plan as appropriate. Hearing aids must be purchased and fitted by a Pennsylvania registered hearing aid fitter, licensed audiologist, or licensed physician associated with a registered hearing aid dealer. Hearing aid purchases are limited to once every three years.

Important Note: The language of the CHC governing documents (provided in the attached chart) do not list audiologists as an appropriate prescriber for hearing aids. Check with your CHC-MCO and ask if they will accept a prescription from a licensed audiologist for an evaluation for hearing aids under CHC.

- **Vehicle Modifications:** Prescriber: Depending on the type of modification, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist, physical therapist or mobility specialist meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. *See attached chart for more information on Vehicle Modification coverage*.

Who Can Provide AT devices?

- **Medicare Durable Medical Equipment (DME):** Approved DME Provider. Use this link to enter your zip code and find approved DME Providers in your area: https://www.medicare.gov/supplierdirectory/search.html
- **Medicaid Durable Medical Equipment (DME):** Home Health Agencies, Medical Suppliers, and Pharmacies that are within the CHC-MCO's network or approved out-of-network providers. Use these plan contact numbers and websites to either contact the CHC-MCO's Participant Services Department and ask about the provider network or search the CHC-MCO's online provider directory on their website:
  - **AmeriHealth Caritas/Keystone First Community HealthChoices:** 1-855-235-5115 (TTY: 1-855-235-5112) www.amerihealthcaritaschc.com
  - **Pennsylvania Health & Wellness:** 1-844-626-6813 (TTY: 1-844-349-8916) www.PAHealthWellness.com
  - **UPMC Community HealthChoices**: 1-844-833-0523 (TTY: 1-866-407-8762) www.upmchealthplan.com/chc
- **Assistive Technology:** Permissible Provider: a Contractor or a DME Agency that are within the CHC-MCO's network or approved out-of-network providers.
- **Exceptional DME:** Permissible Provider: Nursing Facilities may use Medicaid approved contractors for procuring these items for residents who require them.
- **Home Adaptation:** Permissible Provider: a Contractor or a DME Agency that are within the CHC-MCO's network or approved out-of-network providers.
- **Specialized Medical Equipment and Supplies:** Permissible Provider: a Pharmacy, a DME Agency, a Hearing Aid Dealer that are within the CHC-MCO's network or approved out-of-network providers.
- **Vehicle Modifications:** Permissible Provider: Vehicle Modifications Contractor that are within the CHC-MCO's network or approved out-of-network providers.

  Important Notes: Remember to make sure the provider is participating in the Participant's CHC-MCO network. Also, most adapted vehicle vendors can provide an independent evaluation if they have a mobility specialist on site.

How Does an AT Provider Become a CHC Provider?

There are several steps to becoming an approved provider, beginning with becoming a Medicaid-approved provider. Below you will find an enrollment checklist, a base (standard) application and HCBS-specific application which are part of the Medicaid enrollment process.

1) Enrollment Checklist - http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_209454.pdf

2) Provider Enrollment Base Application – http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_209450.pdf
3) Provider Enrollment – specific services - http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_209451.pdf

Additionally, a provider will have to apply separately to each of the CHC-MCOs. CHC-MCO provider enrollment contact information for each plan is as follows:

1) AmeriHealth Caritas/Keystone First: CHCProviders@amerihealthcaritas.com or 1-800-521-6007
2) Pennsylvania Health and Wellness: information@pahealthwellness.com or 1-844-626-6813 (select option 3)
3) UPMC: CHCProviders@upmc.edu or 1-844-860-9303

Important Note: AT vendors may need encouragement and help to understand the process of enrolling and joining a CHC-MCO provider network.

Can Out-of-Network Providers Provide AT Devices?

Generally, to provide CHC Covered Services, a provider must be a provider that has been approved through the Pennsylvania Medicaid program and a participating provider within the CHC-MCO's provider network. Participants may use out-of-network providers who do not have a contract with the Participant's CHC-MCO when they are obtaining CHC covered services if they obtain permission from their CHC-MCO. The CHC-MCO must give permission when it cannot offer a choice of two qualified providers or does not have an adequate number of providers within the time and distance standards.

Important Note: Participants should not shy away from asking for out-of-network AT vendors when their CHC-MCO network does not have a vendor or has an insufficient number.

What Standard is Applied to Requests for AT?

AT devices that would be covered under Medicare or the Medicaid State Plan coverage are generally subject to a fixed coverage standard or "medical necessity" determination. Typically, AT devices covered under the Medicaid HCBS Waiver must be covered if the device would help the Participant achieve a more independent and productive life and a request does not need to satisfy a "medical necessity" standard.

Important Note: According to the approved CHC HCBS Waiver, AT devices will only be approved when an independent evaluation specifies that the item is primarily used for a Participant's specific therapeutic purpose and serves as a less costly alternative than other suitable devices and alternative methods. This is confusing and appears to narrow other Waiver language that more broadly says that AT is intended to ensure the health, welfare and safety of the Participant and to increase, maintain or improve a Participant's functioning in communication, self-help, self-direction, life supports or adaptive capabilities. Participants should obtain approval for any AT that helps him/her achieve a more independent and productive life. If a Participant's Medicare denies coverage, the CHC-MCO should review whether the device is coverable under the Medicaid State Plan and under the CHC HCBS Waiver package of services.

How Exactly Does CHC Define AT Services?

Attached is a chart providing you the exact language used by the state to define services. This language comes directly from the CHC Waiver and/or CHC-MCO Agreement. This language will be important to have when advocating with CHC-MCOs.

How to Get Help if Your Request is Denied?

If your request for AT is denied, you (the Participant) can challenge the denial by requesting a "grievance" from your CHC-MCO's Member Services. Instructions are on the denial notices. Make sure you save all denial notices or other written documents from the CHC-MCO. Call the Pennsylvania Health Law Project at (800) 274-3258 for free assistance in understanding your right to appeal or in appealing the CHC-MCO's decision. The Department of Human Services (DHS) also recommends calling your local legal services office at (877) 429-5994.

It may also be helpful to check the Department of Human Services' website, http://www.healthchoices.pa.gov/info/resources/publications/community/index.htm, to find the most up-to-date information.

Who Do I Contact at the Plan with AT Problems?

Each CHC-MCO has a designated point person for addressing AT questions and issues. These are:

- *AmeriHealth Caritas / Keystone First – Danielle Bruette, 484-496-7635, dbruette@amerihealthcaritas.com*
- *PA Health and Wellness – Scott W. Evans, 717.551.7133, Scott.W.Evans@pahealthwellness.com*
- *UPMC – Andrea Farrell, 412.454.5685, farrellam2@upmc.edu*

Where Can I Find a Copy of the Community HealthChoices Waiver?

A copy of the Community HealthChoices Waiver can be found on the Department of Health Service's website, http://www.dhs.pa.gov/searchresults/index.htm?q=Community+HealthChoices+Waiver or by going to http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_264258.pdf.

Names and Definitions of CHC Services that include AT – *Excerpted from the CHC Waiver Application and CHC-MCO Agreement*	
Definition	Source: Waiver Application[1] and CHC Agreement[2]
Assistive Technology	Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized — that is needed by the participant, as specified in the participant's person-centered service plan (PCSP) and determined necessary in accordance with the participant's assessment. The service is intended to ensure the health, welfare and safety of the participant and to increase, maintain or improve a participant's functioning in communication, self-help, self-direction, life supports or adaptive capabilities. Assistive Technology includes supports to a participant in the selection, acquisition or use of an Assistive Technology device. Training to utilize adaptations, modifications and devices is included in the purchase, as applicable. Independent evaluations conducted by a certified professional, not otherwise covered under the State Plan or other waiver services, may be reimbursed as a part of this service. Assistive Technology is limited to: • Services consisting of purchasing, leasing or otherwise providing for the acquisition of Assistive Technology devices for participants; • Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing Assistive Technology devices. Repairs are covered when it is more cost effective than purchasing a new device; • Electronic systems[3] that enable someone with limited mobility to control various appliances, lights, telephone, doors and security systems in their room, home or other surroundings; • Training or technical assistance for the participant, paid caregiver and unpaid caregiver; • An independent evaluation of the Assistive Technology needs of a participant. This includes a functional evaluation of the Assistive Technology needs and appropriate services for the participant in his/her customary environment; • Extended warranties; • Ancillary supplies, software and equipment necessary for the proper functioning of Assistive Technology devices, such as replacement batteries and materials necessary to adapt low-tech devices. This includes applications for electronic devices that assist participants with a need identified through the evaluation described below; and • Generators to power life-sustaining equipment, which are covered for participants residing in private homes when the following has been documented: The generator purchased is the most cost-effective to ensure the health and safety of the participant; AND the participant's health and safety is dependent upon electricity as documented by a physician. All items shall meet the applicable standards of manufacture, design and installation. If the participant receives Speech, Occupational or Physical Therapy or Behavior Support services that may relate to, or are impacted by, the use of the Assistive Technology, the Assistive Technology must be consistent with the participant's behavior support plan or Speech, Occupational or Physical Therapy service. Specify applicable (if any) limits on the amount, frequency, or duration of this service: Assistive Technology services may only be funded through the waiver when the services are not covered by the State Plan or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan or a responsible third-party continues until the State Plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable. This service excludes those items that are not of direct medical or remedial benefit to the participant. Assistive Technology devices must be recommended by an independent evaluation or physician's prescription. They will only be approved by the OLTL when an independent evaluation specifies that the item is primarily used for a participant's specific therapeutic purpose and serves as a less costly alternative than other suitable devices and alternative methods.

[1] The Community HealthChoices Waiver Application outlined to CMS, and was approved by CMS, included a list of the services (including service definitions) that DHS proposed to include in the CHC program.

[2] The Community HealthChoices agreement outlines the requirements in place for each managed care plan (CHC-MCO), including the list of which services the CHC-MCOs must cover and the service definitions for many of those services.

[3] *Important Note: Electronic systems include electronic devices and smart home technology.*

Names and Definitions of CHC Services that include AT – *Excerpted from the CHC Waiver Application and CHC-MCO Agreement*	
	The following are specifically excluded from this service definition: • Recreational items • Items that do not provide direct remedial benefit or improve the participant's ability to communicate with others. Depending on the type of technology, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech, hearing or language therapist; physical therapist; or other certified professional meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Independent evaluations conducted by a certified professional as defined in the provider qualifications for this service, not otherwise covered under the State Plan or other waiver services, may be reimbursed as a part of this service. Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service. This service does not include TeleCare services. Data plans are excluded from coverage.
Home Adaptations *(see chart below for more information on the process of requesting a Home Adaptation under CHC)*	Home Adaptations are physical adaptations to the private residence of the participant, as specified in the participant's person-centered service plan (PCSP) and determined necessary in accordance with the participant's assessment, to ensure the health, welfare and safety of the participant, and enable the participant to function with greater independence in the home. This includes primary egress into and out of the home, facilitating personal hygiene, and the ability to access common shared areas within the home. Home Adaptations consist of installation, repair, maintenance, permits, necessary inspections, extended warranties for the adaptations. Adaptations to a household are limited to the following: • Ramps from street, sidewalk or house; • Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the health, welfare and safety of the participant; • Vertical lifts; • Track lift systems: A track lift system involves the installation of a "track" in the ceiling for moving a participant with a disability from one location to another. (Note: Portable lift systems are covered by the MA State Plan)[4]; • Handrails and grab-bars in and around the home; • Accessible alerting systems for smoke/fire/carbon monoxide for participants with sensory impairments; • Outside railing to safely access the home; • Widened doorways, landings and hallways; • Swing-clear and expandable offset door hinges; • Flush entries and leveled thresholds; • Slip resistant flooring; • Kitchen counter, sink and other cabinet modifications (including brackets for appliances); • Bathroom adaptations for bathing, showering, toileting and personal care needs; • Stair gliders and stair lifts. A stair lift is a chair or platform that travels on a rail, installed to follow the slope and direction of a staircase, which allows a user to ride up and down stairs safely; • Raised electrical switches and sockets; and • Other adaptations, subject to OLTL approval, to address specific assessed needs as identified in the service plan. All adaptations to the home shall be provided in accordance with applicable building codes. Home Adaptations shall meet standards of manufacture, design and installation. Home Adaptations must be an item of modification that the family would not be expected to provide to a family member without a disability or specialized needs. Specify applicable (if any) limits on the amount, frequency, or duration of this service: This service is not covered in the State Plan. Home Adaptations may only be funded through the waiver when the services are not covered by a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with OLTL requirements must be maintained in the participant's file by the Service Coordinator and updated with each authorization.

[4] *Important Note: Many people are not aware that track lifts are often available through Medicare and private insurance.*

	This service does not include, but requires, an independent evaluation. Depending on the type of adaptation, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech, hearing and language therapist; or physical therapist meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through another waiver service, as appropriate. Home Adaptations included in the service plan and begun while the person was institutionalized are not considered complete and may not be billed until the date the participant leaves the institution and enters the waiver. Home adaptations must be obtained at the lowest cost. Building a new room is excluded. Specialized Medical Equipment and Supplies is excluded. Also excluded are those adaptations or improvements to the home that are of general maintenance and upkeep and are not of direct medical or remedial benefit to the participant this includes items that are not up to code. Adaptations that add to the total square footage of the home are excluded from this benefit, except when necessary for the addition of an accessible bathroom when the cost of adding the bathroom is less than retrofitting an existing bathroom. Materials and equipment must be based on the participant's need as documented in the PCSP. Rented property adaptations must meet the following: • There is a reasonable expectation that the participant will continue to live in the home; • Written permission is secured from the property owner for the adaptation, including that there is no expectation that waiver funds will be used to return the home to its original state; and • The landlord will not increase the rent because of the adaptation. Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service. This service may not be included on the same service plan as Residential Habilitation.
Specialized Medical Equipment and Supplies	Specialized Medical Equipment and Supplies are services or items that provide direct medical or remedial benefit to the participant and are directly related to a participant's disability. These services or items are necessary to ensure health, welfare and safety of the participant and enable the participant to function in the home and community with greater independence. This service is intended to enable participants to increase, maintain, or improve their ability to perform activities of daily living. Specialized Medical Equipment and Supplies are specified in the participant's PCSP and determined necessary in accordance with the participant's assessment. Specialized Medical Equipment and Supplies includes: • Devices, controls or appliances, specified in the service plan, that enable participants to increase, maintain or improve their ability to perform activities of daily living; • Equipment repair and maintenance, unless covered by the manufacturer warranty; • Items that exceed the limits set for Medicaid State plan covered services; and • Rental Equipment. In certain circumstances, needs for equipment or supplies may be time-limited. The Service Coordinator must initially verify that the rental costs cannot be covered by the State Plan. If the State Plan does not cover the rental for the particular piece of equipment needed, then the cost of the rental can be funded through Specialized Medical Equipment and Supplies Non-Covered Items: • All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream); • Items covered under third party payer liability; • Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's disability; • Food, food supplements, food substitutes (including formulas), and thickening agents; • Eyeglasses, frames, and lenses; • Dentures; • Any item labeled as experimental that has been denied by Medicare and/or Medicaid; and • Recreational or exercise equipment and adaptive devices for such. (*Examples of Specialized Medical Equipment and Supplies include hearing aids, catheters, incontinence supplies, seat cushions, wheelchairs, and specialized mattresses.)* All items shall meet applicable standards of manufacture, design and installation. If the participant receives Speech, Occupational, or Physical Therapy or

	Behavior Support services that may relate to, or are impacted by, the use of the Specialized Medical Equipment and Supplies, the Specialized Medical Equipment and Supplies must be consistent with the participant's behavior support plan or Speech, Occupational or Physical Therapy service. Specify applicable (if any) limits on the amount, frequency, or duration of this service: Specialized Medical Equipment and Supplies may only be funded through the waiver when the services are not covered by the State Plan or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan or a responsible third-party continues until the State Plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the participant's file by the Service Coordinator and updated with each reauthorization, as applicable. This service does not include, but requires, an independent evaluation and a physician's prescription. The independent evaluation may be conducted by an occupational therapist; a speech, hearing or language therapist; or physical therapist meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through one of the following services offered through the waiver; Physical Therapy, Occupational Therapy, or Speech Therapy, or the State Plan as appropriate. Hearing Aids require, but this service does not cover, an evaluation conducted by a physician certified by the American Board of Otolaryngology (ear, nose, and throat physician). Hearing aids must be purchased and fitted by a Pennsylvania registered hearing aid fitter, licensed audiologist, or licensed physician associated with a registered hearing aid dealer. Hearing aid purchases are limited to once every three years. Specialized Medical Equipment and Supplies exclude Assistive Technology. Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.
Vehicle Modifications	Vehicle Modifications are modifications or alterations to an automobile or van that is the participant's means of transportation in order to accommodate the special needs of the participant. Vehicle Modifications are modifications needed by the participant, as specified in the service plan and determined necessary in accordance with the participant's assessment, to ensure the health, welfare and safety of the participant, and enable the participant to function in the home and community with greater independence and integrate more fully into the community. The vehicle that is modified may be owned by the participant, a family member with whom the participant lives, or a non-relative who provides primary support to the participant and is not a paid provider agency of services. The following are specifically excluded: • Modifications or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the participant; and • Regularly scheduled upkeep and maintenance of a vehicle, including warranties that cover the entire vehicle, except upkeep and maintenance of the modifications. The waiver cannot be used to purchase chassis for participants, their families or legal guardians; however, this service can be used to fund the portion of a new or used vehicle purchase that relates to the cost of accessibility adaptations. In order to fund these types of adaptations, a clear breakdown of purchase price versus adaptation is required. Vehicle Modifications funded through the waiver are limited to the following: • Vehicular lifts; • Portable ramps when the sole purpose of the ramp is for the participant to access the vehicle; • Interior alterations to seats, head and leg rests, and belts; • Customized devices necessary for the participant to be transported safely in the community, including tie-downs and wheelchair docking systems; • Driver control devices, including hand controls and pedal adjusters; • Modifications needed to accommodate a participant's special sensitivity to sound, light or other environmental conditions; • Raising the roof or lowering the floor to accommodate wheelchairs; and • The vehicle must be less than 5 years old and have less than 50,000 miles for vehicle modification requests over $3,000. All Vehicle Modifications shall meet applicable standards of manufacture, design and installation. Specify applicable (if any) limits on the amount, frequency, or duration of this service: A vehicle is required to have passed all applicable State standards. This service does not include, but requires, an independent evaluation.

Names and Definitions of CHC Services that include AT – *Excerpted from the CHC Waiver Application and CHC-MCO Agreement*	
	Participants receiving Vehicle Modifications cannot be authorized for Residential Habilitation services during the same time period. Depending on the type of modification, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist, physical therapist or Mobility Specialist meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through another waiver service or the State Plan, as appropriate.

Home Adaptations Request Process			
Question	Keystone First	PA Health & Wellness (PHW)	UPMC
How long does a service coordinator (SC) have to submit a request for an assessment, if needed, for a home modification after the participant has requested the service?	After a Comprehensive Needs Assessment has been completed that identifies the need for a home adaptation, the service coordinator (SC) will secure an independent evaluation (by a physical, occupational or speech therapist) of the participant in his/her home to ensure that the proposed adaptations are suitable to enhance the independence and safety of the participant. The evaluation will be reviewed with the participant, SC, NHT (Nursing Home Transition) coordinator (when applicable), and members the participant's Person-Centered Service Plan Team (PCPT.)	Service coordinators (SCs) and Service Coordinating Entities (SCEs) are required to submit requests within 24-hours of receiving the request, excluding holidays and weekends.	Service coordinators (SCs) are expected to complete a request within 5 business days of receiving the request from a participant.
How long does the Managed Care Organization (MCO) have to respond to a request for a home adaptation (home modification)?	The MCO works with the participant, SC, NHT coordinator (when applicable) and all others who involved in order to gather the information (identify the need and provide a justification) to review the request. Home adaptations require an independent evaluation in the participant's home environment no greater than 90 days prior to submission for review.	PHW will respond with its standard turnaround times. PHW will review the prior authorization request and information that the participant or provider submits. PHW will inform the participant & provider of the decision within 2 business days of the date PHW received the request assuming PHW has enough information to decide that the service or item is medically necessary and the service is appropriate. If PHW does not have enough information to make the determination, PHW will tell the provider within 48 hours of receiving the request that more information is needed. The participant or provider has up to 14 days to gather and present the information to PHW. PHW will notify the participant and provider of the decision within 2 business days of receiving the additional information. The participant and provider will receive a written notice telling him/her if the request is approved or denied; and if denied, the reason for the denial.	The MCO will confirm receipt of the request and will respond as quickly as possible. Defined time limits will be provided in the forthcoming policy document.
How long does the SC have to compile the needed information and bids to submit to the MCO?	The SC is trained to secure all required adaptation information as expeditiously as possible. Any home adaptation request $6,800 or larger will require two contractor estimates. Home adaptations must be obtained at the lowest cost.	Required documentation should be submitted as soon as possible but no more than 14 days from the date of request. It is not the responsibility of the SC/SCE to obtain the bids – rather, this is the responsibility of the Program Coordination unit.	The SC is not required by UPMC to compile bids before submitting a request for review. There is a request form that the SC fills out that gives provides the MCO with the information about the participant, his/her home, and the requested

			modifications. If the participant is eligible, and the modifications are allowed under the service definition, then the project moves on to independent evaluation so that the scope can be clearly defined by an expert before multiple providers submit bids.
How long does the MCO have to review the request?	The MCO will follow the review criteria outlined in the CHC agreement when a request contains all of the necessary information and documentation.	PHW will respond with its standard turnaround times. PHW will review the prior authorization request and information that the participant or provider submit. PHW will inform the participant & provider of the decision within 2 business days of the date PHW received the request if PHW has enough information to decide if the service or item is medically necessary and service appropriate. If PHW does not have enough information to decide the request, PHW will tell the provider within 48 hours of receiving the request. The participant or provider has 14 days to gather and present the information that is requested. PHW will notify the participant and provider of the decision within 2 business days of receiving the additional information. The participant and provider will receive a written notice telling him/her if the request is approved or denied; and if denied, the reason for the denial.	The defined time limit will be outlined in the policy document.
If denied (for a portion or for the entire request), how long does the SC have to "fix" the issue, to obtain another bid, or to notify the participant?	When a request is incomplete, the SC must submit the completed information within 14 days. (This is in accordance of the CHC agreement.)	N/A. Standard complaint, grievance and appeal procedures apply.	When a denial is issued, the participant has an opportunity to appeal the decision. UPMC does not have SCs re-working denied requests.
Once approved, how long does the MCO have to complete the home modification?	The MCO works with the participant, authorized contractor, SC, and NHT coordinator (when applicable) to determine the time frame for the full scope of work (including the construction and installation.) The MCO will oversee the project through completion.	The time line varies based on participant, provider and PHW coordination. PHW will monitor progress on a weekly basis until complete.	All authorizations, including home modifications, are valid for 6 months. UPMC is working on defining tighter time limits for the providers to complete work and submit his/her close-out documentation. More detail will be provided in the new policy.