

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Includes Changes Implemented through May 2014

Submitted by:

Utah Department of Health, Division of Medicaid and Health Financing

Submission Date: 03/31/2016

CMS Receipt Date (CMS Use)

Describe any significant changes to the approved waiver that are being made in this renewal application:

The state is proposing minor changes to the Physical Disabilities Waiver (PD Waiver). No new services are being recommended as PD Waiver participant surveys have demonstrated general satisfaction with waiver services currently offered. The minor changes proposed include the following:

Service Modifications

- There will be no new services added to the PD Waiver program and no services will be removed.
- The existing Personal Attendant Service description was updated to further detail how the service is to be provisioned with added clarification that transportation costs associated with this service are not covered.

Change to General Service Specifications

- Waiver language was altered to reflect changes as a result of R501-14 which was recently amended. All providers under the Self-Administered Service Model are now required to receive a criminal background check, including the family members of waiver participants.

Quality Improvement

Incident reporting requirements were updated to reflect current State Medicaid Agency (SMA) protocol. Incidents are grouped by severity into three distinct categories and investigated accordingly.

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Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors.

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1. Request Information

A. The State of Utah requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional – this title will be used to locate this waiver in the finder*):

Physical Disabilities Waiver

C. **Type of Request:** (*the system will automatically populate new, amendment, or renewal*)

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

<input type="radio"/>	3 years
<input type="radio"/>	5 years

<input type="checkbox"/>	New to replace waiver Replacing Waiver Number:
<input type="checkbox"/>	Migration Waiver – this is an existing approved waiver Provide the information about the original waiver being migrated
Base Waiver Number:	UT.0331
Amendment Number (if applicable):	
Effective Date: (mm/dd/yy)	

D. **Type of Waiver** (*select only one*):

<input type="radio"/>	Model Waiver
<input checked="" type="radio"/>	Regular Waiver

E. **Proposed Effective Date:** 07/01/16

Approved Effective Date (*CMS Use*):

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

<input type="checkbox"/>	Hospital (<i>select applicable level of care</i>)
<input type="radio"/>	Hospital as defined in 42 CFR §440.10 If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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	<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
X		Nursing Facility (<i>select applicable level of care</i>)
	X	Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155 If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input type="checkbox"/>		Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150) If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID facility level of care:

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G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

<input checked="" type="radio"/>	Not applicable		
<input type="radio"/>	Applicable		
Check the applicable authority or authorities:			
<input type="checkbox"/>	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I		
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):			
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program operated under §1932(a) of the Act. <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:</i>		
<input type="checkbox"/>	A program authorized under §1915(i) of the Act.		
<input type="checkbox"/>	A program authorized under §1915(j) of the Act.		
<input type="checkbox"/>	A program authorized under §1115 of the Act. Specify the program:		

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

<input checked="" type="checkbox"/>	This waiver provides services for individuals who are eligible for both Medicare and Medicaid.
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2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The PD Waiver program provides services and supports to people with significant physical disabilities as described in Appendix B-1 who live in the community. It is designed to be consistent with a service delivery system that promotes and supports participant self-determination, maintains a high standard of quality in services and supports and maximizes the distribution and utilization of public funds, both state and federal. The SMA has entered into an interagency agreement for the day-to-day administration and operation of the PD Waiver with the Utah Department of Human Services, Division of People with Disabilities (DSPD). The SMA retains final administrative authority over the PD Waiver program.

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3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one):*

<input checked="" type="checkbox"/>	Yes. This waiver provides participant direction opportunities. <i>Appendix E is required.</i>
<input type="checkbox"/>	No. This waiver does not provide participant direction opportunities. <i>Appendix E is not required.</i>

- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State’s demonstration that the waiver is cost-neutral.

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4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

<input type="radio"/>	Not Applicable
<input type="radio"/>	No
<input checked="" type="radio"/>	Yes

- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

If yes, specify the waiver of statewide that is requested (*check each that applies*):

<input type="checkbox"/>	<p>Geographic Limitation. A waiver of statewide is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.</p> <p><i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>
<input type="checkbox"/>	<p>Limited Implementation of Participant-Direction. A waiver of statewide is requested in order to make <i>participant direction of services</i> as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.</p> <p><i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>

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5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
 1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
 1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan

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and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

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6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity

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and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

In the process of drafting this renewal application, the SMA convened a workgroup comprised of advocates, providers, participant family members and staff from both the Bureau of Authorization and Community Based Services, Utah Department of Health, and the Division of Services for People with Disabilities (DSPD), Department of Human Services. The workgroup convened as part of the drafting process participated in four workgroup sessions. Utilizing feedback from the group, proposed changes were implemented into a draft renewal application. Additionally, feedback from DSPD’s PD Waiver survey known as the Tour de Utah was also considered by the workgroup when drafting the renewal application. The Tour de Utah is a survey geared to identify additional needs of the PD Waiver population. As needs are identified, the survey is designed to help guide the PD Waiver program in considering policy changes to enhance the array of available service options accessible through the PD Waiver.

The State met with both the Utah Indian Health Advisory Board (UIHAB) and the Utah Centers for Independent Living (CILs) in March of 2016 to discuss proposed changes to the PD Waiver previously sent to them and to obtain their feedback for incorporation into the proposed PD Waiver renewal application. The Medical Care Advisory Committee (MCAC), Employment Partnership (EP) and Disability Advisory Council (DAC) were also notified of the upcoming renewal application in February of 2016. On February 12, 2016, the full draft renewal application was sent to a wide network of providers, consumers, governmental entities and other interested parties including the UIHAB, CILs, MCAC, EP, DAC, Disability Law Center, Utah Legislative Coalition, Utah Statewide Independent Living Council and the Utah Developmental Disabilities Council for review. The proposed renewal application was also posted on the SMA’s website at <http://www.health.utah.gov/ltc>. Notification was also published in the newspaper to help make the public aware of the application and how to submit public comment.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State’s intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

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7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Hales			
First Name:	Tonya			
Title:	Director, Bureau of Authorization and Community Based Services			
Agency:	Department of Health, Division of Medicaid and Health Financing			
Address :	288 N. 1460 W.			
Address 2:	PO Box 143112			
City:	Salt Lake City			
State:	Utah			
Zip:	84114-3112			
Phone:	(801) 538-9136	Ext:	<input type="checkbox"/>	TTY
Fax:	(801) 323-1588			
E-mail:	thales@utah.gov			

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Smith			
First Name:	Paul			
Title:	Division Director			
Agency:	Department of Human Services, Division of Services for People with Disabilities			
Address:	195 N. 1950 W.			
Address 2:				
City:	Salt Lake City			
State:	Utah			
Zip :	84116			
Phone:	(801) 538-8299	Ext:	<input type="checkbox"/>	TTY
Fax:	(801) 538-4279			
E-mail:	ptsmith@utah.gov			

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8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

Submission Date:	
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 State Medicaid Director or Designee

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:	Hales			
First Name:	Michael			
Title:	Deputy Director			
Agency:	Utah Department of Health			
	Division Director, Division of Medicaid and Health Financing			
Address:	288 N. 1460 W.			
Address 2:	PO Box 143112			
City:	Salt Lake City			
State:	Utah			
Zip:	84114-3112			
Phone:	(801) 538-6965	Ext:	<input type="checkbox"/>	TTY
Fax:	(801) 538-6860			
E-mail:	mthales@utah.gov			

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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

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Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The SMA will complete the HCBS Settings Transition Plan for the Physical Disabilities Waiver in a manner consistent with the overall approach developed and submitted to CMS in the Statewide HCBS Transition Plan. The Statewide HCBS Transition Plan was submitted to CMS on March 17, 2015.

An overview of this plan is as follows:

Public Notice and Comment Process:

1. Following the development/posting of the initial plan on October 22, 2014 the SMA accepted public comment through December 1, 2014.
2. Based on the feedback received, the SMA has completed revisions to the draft plan. A revised draft was posted for comment on February 2, 2015. Comment was then accepted for an additional 30 day period and ended on March 5, 2015. Any future iterations of the plan will be made available for public comment for a minimum of 30 days with notice provided through various channels including: Newspaper articles; online forums such as emails/listservs/websites as well as hard copies.
3. The State will solicit public input on assessment and remediation tools as they are developed.
4. The SMA will retain and summarize all public comment received and modify the Transition Plan as it deems appropriate. These summaries are provided to CMS with an explanation of whether comments received led to modifications in the Transition Plan.

Assessment Process:

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1. The SMA established a Workgroup that is meeting periodically, reviewing draft documents including evaluations tools, interim reports and progress through the stages of the Transition Plan. This group is being used to reach out to a broader group of stakeholders for feedback and to assist in the participation of public comment opportunities. The first meeting of this group was held on February 25, 2015.
2. The SMA conducted a review of HCBS Waiver sites of services and made preliminary categorization. The SMA has reported the results of the review of PD Waiver providers in the Additional Needed Information (Optional) section below.
3. The state will send an informational letter to providers that describes appropriate HCBS setting requirements, and transition plan assessment steps that will include State review and provider self-assessment. The letter will describe providers' ability to remediate issues to come into compliance within deadlines and that technical assistance will be available throughout the process.
4. Utilizing tools from the CMS HCBS Settings Review Toolkit, the SMA will complete a categorization of settings to determine sites likely to be Fully Compliant, Not Yet Compliant or Not Compliant with HCBS characteristics. This process will include determining sites that are presumed to have institutional like qualities. These sites will be identified as requiring heightened scrutiny.
5. The SMA will create a Provider Self-Assessment Tool which will include questions to identify sites that may be presumed to have institutional like qualities. Providers categorized as Not Yet Compliant or Not Compliant will be required to complete and submit the results of their self-assessment to the SMA.
6. The SMA will modify tools used in contract/certification/licensing reviews of providers categorized as Not Yet Compliant or Not Compliant as well as for periodic reviews of existing and new providers to ensure compliance with the HCBS settings requirements. Tools will be modified to review compliance of enrolled providers on an ongoing basis thereafter.
7. A final categorization Compliant/Not Yet Compliant (including those requiring heightened scrutiny)/Not Compliant will be completed for all providers. Notification of these results will be given to each provider.

Remediation Strategies:

1. The SMA will modify HCBS Waiver provider enrollment documents to provide education and assure compliance with HCBS setting requirements prior to enrolling new providers. This process will include provider acknowledgement of the settings requirements. HCBS Provider Manuals will be revised to incorporate the settings requirements and clarify requirements in person-centered planning.
2. Based on the individual provider assessments the SMA, providers and stakeholders will collaborate to create a remediation plan for the provider, establish timelines and monitor progress made towards compliance.
3. For individual waiver clients, any modifications of conditions under 42 CFR §441.301 (c)(4)(vi)(A) through (D) are supported by a specific assessed need and justified in the individual client's person-centered service plan.
4. A determination/final disposition of sites identified as requiring heightened scrutiny will be completed.
5. The SMA will create a system to track provider progress toward, and completion of, an individual remediation plan. The system will have the ability to show compliance by individual waiver and for all HCBS waiver programs.
6. On-site reviews will be conducted for providers who have completed their remediation plans utilizing the compliance tools developed. The SMA will disenroll and/or sanction providers that have failed to implement the individual provider remediation plan or those determined through the heightened scrutiny process to have institutional like qualities that cannot be remediated.

Quarterly updates will be provided to CMS, providers and stakeholders until the remediation strategies have been completed.

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Utah assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Utah will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

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Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

<input type="radio"/>	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (<i>select one</i>):
<input type="radio"/>	The Medical Assistance Unit (<i>specify the unit name</i>) (<i>Do not complete Item A-2</i>)
<input type="radio"/>	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit. Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (<i>Complete item A-2-a</i>)
<input checked="" type="checkbox"/>	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. Specify the division/unit name:
	The Division of Services for People with Disabilities (DSPD)
	In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (<i>Complete item A-2-b</i>).

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities.

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b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Home and Community Based Services Waiver-Division of Services for People with Disabilities Interagency Agreement (Interagency Agreement) between the State Medicaid Agency (SMA) and DSPD sets forth the respective responsibilities for the administration and operation of the PD Waiver. This Interagency Agreement runs for a five year period, but can be amended as needed.

The Interagency Agreement delineates the SMA’s overall responsibility to provide management and oversight of the PD Waiver, as well as DSPD’s operational and administrative functions.

The responsibilities of DSPD as the Operating Agency (OA) are delegated as follows. Most of these responsibilities are shared with the SMA:

1. Program Development
2. Rate Setting and Fiscal Accountability
3. Program Coordination, Education and Outreach
4. HCBS Waiver Staffing Assurances
5. Eligibility Determination and Waiver Participation Assurances
6. Waiver Participant Involvement in Decision Making
7. Hearings and Appeals
8. Monitoring, Quality Management and Quality Improvement
9. Reporting
10. Data Security

The SMA monitors the Interagency Agreement through a series of quality assurance activities, provides ongoing technical assistance and reviews and approves all rules, regulations and policies that govern PD Waiver operations. There is a focused program review conducted annually by the SMA Quality Assurance Team. If ongoing or focused annual reviews conducted by the SMA Quality Assurance Team reveal concerns with compliance, DSPD is required to develop plans of correction within specific time frames to correct the problems. The SMA Quality Assurance Team conducts follow up activities to ensure that corrections are sustaining.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

<input type="radio"/>	Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i>
<input checked="" type="radio"/>	No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select one*):

<input checked="" type="radio"/>		Not applicable
<input type="radio"/>		Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
<input type="checkbox"/>		<p>Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i></p>
<input type="checkbox"/>		<p>Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i></p>

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

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7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	X	X	<input type="checkbox"/>	<input type="checkbox"/>

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Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities..

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- *Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver*
- *Equitable distribution of waiver openings in all geographic areas covered by the waiver*
- *Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014).*

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure 1:	Number and percentage of OA annual reports specified in the implementation plan that were submitted to the SMA on time and in the correct format. The numerator is the number of reports submitted to the SMA by the OA in the proper format and within required timeframes; the denominator is the total number of all reports submitted to the SMA by the OA.		
Data Source (Select one) (Several options are listed in the on-line application):			
<i>If 'Other' is selected, specify:</i>			
DSPD Annual reports and DSPD Annual Incident report			
	Responsible Party for	Frequency of data	Sampling Approach

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	data collection/generation (check each that applies)	collection/generation: (check each that applies)	(check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure 2:	Number and percentage of documents submitted to and approved by the SMA using the Document Submittal Protocol prior to implementation. The numerator is the total number of documents that were appropriately submitted by the OA; the denominator includes both documents that were correctly submitted and any documents that were not correctly submitted for SMA review prior to implementation.		
Data Source (Select one) (Several options are listed in the on-line application):			
If 'Other' is selected, specify:			
Document Approval forms and DSPD documents			
	Responsible Party for	Frequency of data	Sampling Approach

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	data collection/generation (check each that applies)	collection/generation: (check each that applies)	(check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure 3:	Number and percentage of maximum allowable rates (MARs) for covered Waiver services approved by the SMA. The numerator is the total number of service codes for which the SMA has approved the payment rate prior to their use; the denominator is the total number of MARs allowed in the program.		
Data Source (Select one) (Several options are listed in the on-line application):			
If 'Other' is selected, specify:			
Rate setting meetings minutes, Approval documentation and Correspondence			
	Responsible Party for	Frequency of data	Sampling Approach

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	data collection/generation (check each that applies)	collection/generation: (check each that applies)	(check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure 4:	Number and percentage of participants who have been denied access to the Medicaid waiver program, who were provided timely notice of appeal rights. The numerator is the total number of participants who were denied and received a timely notice of appeal rights; the denominator includes these individuals along with those who may have been denied but did not receive a timely notice.
<i>Data Source (Select one) (Several options are listed in the on-line application):</i>	
<i>If 'Other' is selected, specify:</i>	
The Utah Systems for Tracking Eligibility, Planning and Services (USTEPS)	

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	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	X 100% Review
	X Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		X Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
X State Medicaid Agency	<input type="checkbox"/> Weekly
X Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	X Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure 5: # and percentage % of participants who have a) had a reduction/denial of a waiver service; b) been denied choice of provider if more than one was available; or c) been determined ineligible when previously receiving services, who were provided timely notice of appeal rights. N = # of compliant cases in compliance; D = total # of cases with or without timely notification requiring notification.

Data Source (Select one) (Several options are listed in the on-line application):

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If 'Other' is selected, specify:

USTEPS			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	95% Confidence Level, 5% Margin of Error
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The SMA demonstrates ultimate administrative authority and responsibility for the operation of the PD

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Waiver program through numerous activities including the issuance of policies, rules and regulations relating to the PD Waiver as well as the review and approval of protocols, documents, provider manuals including the PD Waiver provider manual, bulletins, rates and trainings that affect any aspect of PD Waiver operations. The SMA also conducts quarterly meetings with DSPD staff, monitors compliance with the Interagency Agreement, conducts focused annual quality assurance reviews of the PD Waiver program and provides technical assistance to DSPD and other entities within the state that affect the operation of the PD Waiver program.

The SMA verifies compliance with the Administrative Authority performance measures at least annually. The SMA is the entity responsible for official communication with CMS for all issues related to the PD Waiver.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

Individual issues identified that affect the health and welfare of individual participants are addressed immediately. These issues are addressed in a variety of ways, and may include: a) direct contact for additional information if any, and b) informal discussion or formal (written) notice of adverse findings. The SMA will use discretion in determining notice requirements depending on the findings. Examples of issues requiring intervention by the SMA would include: overpayments; allegations or substantiated violations of health and safety; necessary involvement of APS and/or local law enforcement; or issues involving the State’s Medicaid Fraud Control Unit.

To assure the issue has been addressed, DSPD is required to report back to the SMA on the results of their interventions within designated time frames. These time frames are outlined in standard operating procedures or protocols or are stipulated on a case by case basis depending on the nature of a specific issue. A description of issues requiring immediate attention and outcomes are documented in the SMA Final Report (Final Report).

Issues that are less immediate are corrected within designated time frames and are also documented through the Final Report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

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	<input type="checkbox"/> <i>Other Specify:</i>	<i>X Annually</i>
		<input type="checkbox"/> <i>Continuously and Ongoing</i>
		<input type="checkbox"/> <i>Other Specify:</i>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

SELECT ONE WAIVER TARGET GROUP	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input checked="" type="checkbox"/>	Aged or Disabled, or Both - General			
<input checked="" type="checkbox"/>	Aged (age 65 and older)	65	65	X
<input checked="" type="checkbox"/>	Disabled (Physical)	18	64	
<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/>	Aged or Disabled, or Both - Specific Recognized Subgroups			
<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/>	Intellectual Disability or Developmental Disability, or Both			
<input type="checkbox"/>	Autism			<input type="checkbox"/>
<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input type="checkbox"/>	Mental Illness (check each that applies)			
<input type="checkbox"/>	Mental Illness			<input type="checkbox"/>
<input type="checkbox"/>	Serious Emotional Disturbance			<input type="checkbox"/>

- b. Additional Criteria.** The State further specifies its target group(s) as follows:

The individual must:

- 1) Have established programmatic eligibility through the Utah Department of Human Services for state matching funds in accordance with Utah Code Annotated (UCA) § 62A-51 and Utah Administrative Code (UAC) R539-1-6 by meeting the following criteria:
 - a) Have at least one personal attendant trained (or willing to be trained) and available to provide the authorized PD Waiver services in a residence that is safe and can accommodate the personnel and equipment (if any) needed to adequately and safely care for the individual. DSPD will provide information to the individual about potential community resources to assist them in recruiting an attendant.
 - b) Be medically stable, have a physical disability and require at least 14 hours per week of personal assistance services (as described in appendix C of this waiver) in accordance with a physician’s written documentation in order to remain in the community and prevent unwanted institutionalization. For purposes of the PD Waiver, the individual’s qualifying disability and need for personal assistance services are attested to by a medically determinable physical impairment which the physician expects

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to last for a continuous period of not less than 12 months and which has resulted in the individual's functional loss of two or more limbs to the extent that the assistance of another trained person(s) is required in order to accomplish activities of daily living (ADLs)/instrumental activities of daily living (IADLs).

c) Have decision making capability* to select, train and supervise their personal attendant(s) as certified by a physician.

d) Have decision making capability* to manage their own financial and legal affairs.

2) If a person is eligible for more than one of the waivers operated by DSPD, DSPD will educate the individual about their choices and advise them which of the waivers may best meet their needs.

* Individuals possessing decision making capability but having communication deficits or limited English proficiency may select a representative to communicate decisions on the individual's behalf.

- c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

<input type="radio"/>	Not applicable. There is no maximum age limit
<input checked="" type="radio"/>	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit. <i>Specify:</i>
	Clients age from the Disabled (Physical) to the Aged (age 65 and older) target group/subgroup.

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Appendix B-2: Individual Cost Limit

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

<input checked="" type="checkbox"/>	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>	
<input type="checkbox"/>	Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):	
<input type="checkbox"/>	%	A level higher than 100% of the institutional average Specify the percentage:
<input type="checkbox"/>	Other (<i>specify</i>):	
<input type="checkbox"/>	Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. <i>Complete Items B-2-b and B-2-c.</i>	
<input type="checkbox"/>	Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. <i>Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.</i>	
The cost limit specified by the State is (<i>select one</i>):		
<input type="checkbox"/>	The following dollar amount: Specify dollar amount:	
The dollar amount (<i>select one</i>):		
<input type="checkbox"/>	Is adjusted each year that the waiver is in effect by applying the following formula: Specify the formula:	
<input type="checkbox"/>	May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.	

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<input type="radio"/>	The following percentage that is less than 100% of the institutional average:		
<input type="radio"/>	Other: Specify:		

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

--

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
<input type="checkbox"/>	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
<input type="checkbox"/>	Other safeguard(s) (Specify):

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Appendix B-3: Number of Individuals Served

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	140
Year 2	140
Year 3	140
Year 4 (only appears if applicable based on Item 1-C)	140
Year 5 (only appears if applicable based on Item 1-C)	140

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):

<input type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input checked="" type="radio"/>	The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	130
Year 2	130
Year 3	130
Year 4 (only appears if applicable based on Item 1-C)	130
Year 5 (only appears if applicable based on Item 1-C)	130

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- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

<input checked="" type="checkbox"/>	Not applicable. The state does not reserve capacity.		
<input type="checkbox"/>	The State reserves capacity for the following purpose(s). Purpose(s) the State reserves capacity for:		
Table B-3-c			
Waiver Year	Purpose (provide a title or short description to use for lookup):	Purpose (provide a title or short description to use for lookup):	
	Purpose (describe):	Purpose (describe):	
	Describe how the amount of reserved capacity was determined:	Describe how the amount of reserved capacity was determined:	
	Capacity Reserved	Capacity Reserved	
	Year 1		
	Year 2		
	Year 3		
	Year 4 (only if applicable based on Item 1-C)		
	Year 5 (only if applicable based on Item 1-C)		

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

<input checked="" type="checkbox"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="checkbox"/>	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an <i>intra-year</i> limitation on the number of participants who are served in the waiver.

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e. Allocation of Waiver Capacity.

Select one:

<input checked="" type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="radio"/>	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Medicaid recipients who meet the programmatic eligibility requirements as defined in Appendix B-1 are given a choice to either receive services in a Nursing Facility (NF) or through the PD Waiver. The applicant’s choice will be documented in writing, signed by the applicant and maintained as part of the individual record in the Utah Systems for Tracking Eligibility, Planning and Services (USTEPS).

If available capacity exists, individuals may enroll in the PD Waiver. If no available capacity exists in the PD Waiver, the applicant will be advised in writing that he or she may access services through a NF or may wait for open capacity to develop in the PD Waiver. If the individual chooses to wait for open capacity, DSPD provides information about community resources to assist the individual. In addition, if the individual is currently Medicaid eligible, they have access to Medicaid State Plan services.

The State has developed policies prioritizing access to individuals waiting for waiver services. These policies provide opportunities for access to individuals residing in the community and in institutional settings.

DSPD has established a Critical Needs Assessment process by which individuals are ranked to prioritize access to waiver services. A significant component of the Critical Needs Assessment tool addresses the immediacy of the need for services and the individual’s risk in not gaining access to waiver services.

Individuals in nursing facilities do not demonstrate an immediate need for services, nor do they present as being at high risk if waiver services are not extended to them. Individuals in institutional facilities rank extremely low on the prioritization for receipt of waiver services.

The State recognized this problem and initiated a separate process in which individuals in institutional settings may gain access to waiver services. Medicaid recipients residing in nursing facilities, meeting the PD Waiver criteria may gain access to the PD Waiver by having the State general funds, that supported the person in the NF, follow the person into the PD Waiver, i.e., the money-follows-the-person concept.

The State believes the existence of these two access points of admission into the PD Waiver is an equitable methodology to support access from both the institution and the community. This methodology is supported by the State’s Olmstead Advisory Committee and has not resulted in growth of the NF program. The State has chosen to not reserve capacity to accommodate both points of entry.

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The individual tracks do not take priority over each other as each track has its own funding process. Once a person in institutional care (i.e., NF) is ready to transition from the NF and is found eligible to receive services through the PD Waiver, as long as the number of unduplicated participants authorized in the waiver has not been exceeded, the person may begin receiving services.

A person who lives in the community with physical disabilities and who has an immediate need for services is placed on the waiting list. Once the Utah State Legislature provides an allocation, those waiting with the greatest criticality receive funding first until the allocation is expended.

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d. **Phase-In/Phase-Out Time Period.** Complete the following table:

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

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Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. **1. State Classification.** The State is a (*select one*):

<input type="radio"/>	§1634 State
<input checked="" type="radio"/>	SSI Criteria State
<input type="radio"/>	209(b) State

2. Miller Trust State.

Indicate whether the State is a Miller Trust State (*select one*).

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
<input type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input checked="" type="checkbox"/>	SSI recipients
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input checked="" type="checkbox"/>	Optional State supplement recipients
<input checked="" type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
<input checked="" type="radio"/>	100% of the Federal poverty level (FPL)
<input type="radio"/>	% of FPL, which is lower than 100% of FPL Specify percentage:
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
<input type="checkbox"/>	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
<input type="checkbox"/>	Medically needy in 209(b) States (42 CFR §435.330)
<input checked="" type="checkbox"/>	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify:</i>

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Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.

Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*

All individuals in the special home and community-based waiver group under 42 CFR §435.217

Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (*check each that applies*):

A special income level equal to (select one):

300% of the SSI Federal Benefit Rate (FBR)

% A percentage of FBR, which is lower than 300% (42 CFR §435.236)
Specify percentage:

\$ A dollar amount which is lower than 300%
Specify percentage:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at: (*select one*)

100% of FPL

% of FPL, which is lower than 100%

Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:

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Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (select one):

<input checked="" type="checkbox"/>	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (select one):	
<input type="checkbox"/>		Use spousal post-eligibility rules under §1924 of the Act. Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.
<input type="checkbox"/>		Use regular post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (Complete Item B-5-b-1) or under §435.735 (209b State) (Complete Item B-5-c-1). Do not complete Item B-5-d.
<input type="checkbox"/>	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):		
<input checked="" type="checkbox"/>	The following standard included under the State plan (Select one):	
<input type="checkbox"/>	SSI standard	
<input type="checkbox"/>	Optional State supplement standard	
<input type="checkbox"/>	Medically needy income standard	
<input checked="" type="checkbox"/>	The special income level for institutionalized persons (select one):	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="checkbox"/>	%	A percentage of the FBR, which is less than 300% Specify the percentage:
<input type="checkbox"/>	\$	A dollar amount which is less than 300%. Specify dollar amount:
<input type="checkbox"/>	%	A percentage of the Federal poverty level Specify percentage:

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<input type="radio"/>	Other standard included under the State Plan Specify:		
<input type="radio"/>	The following dollar amount Specify dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance: Specify:		
<input type="radio"/>	Other Specify:		
ii. Allowance for the spouse only (select one):			
<input checked="" type="radio"/>	Not Applicable		
<input type="radio"/>	The State provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: Specify:		
Specify the amount of the allowance (select one):			
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: Specify:		
iii. Allowance for the family (select one):			
<input checked="" type="radio"/>	Not Applicable (see instructions)		
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$	The amount specified cannot exceed the higher amount: of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

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<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i>
<input type="radio"/>	Other <i>Specify:</i>
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. Select one:	
<input checked="" type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits <i>Specify:</i>

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c-1. Regular Post-Eligibility Treatment of Income: 209(B) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):			
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>)		
<input type="radio"/>	<input type="radio"/>	The following standard under 42 CFR §435.121 <i>Specify:</i>	
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>):		
	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
	<input type="radio"/>	%	A percentage of the FBR, which is less than 300% <i>Specify percentage:</i>
	<input type="radio"/>	\$	A dollar amount which is less than 300% of the FBR <i>Specify dollar amount:</i>
<input type="radio"/>		%	A percentage of the Federal poverty level <i>Specify percentage:</i>
<input type="radio"/>	Other standard included under the State Plan (<i>specify</i>):		
<input type="radio"/>	The following dollar amount:	\$	<i>Specify dollar amount: If this amount changes, this item will be revised.</i>
<input type="radio"/>	The following formula is used to determine the needs allowance <i>Specify:</i>		
<input type="radio"/>	Other (<i>specify</i>)		
ii. Allowance for the spouse only (<i>select one</i>):			
<input type="radio"/>	Not Applicable (see instructions)		
<input type="radio"/>	The following standard under 42 CFR §435.121 <i>Specify:</i>		
<input type="radio"/>	Optional State supplement standard		

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<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> If this amount changes, this item will be revised. Specify dollar amount:
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i> <input type="text"/>
iii. Allowance for the family (select one)	
<input type="radio"/>	Not applicable (<i>see instructions</i>)
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> The amount specified cannot exceed the higher Specify dollar amount: of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i> <input type="text"/>
<input type="radio"/>	Other (specify): <input type="text"/>
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>): <input type="text"/>

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Effective Date	<input type="text"/>

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules and elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant’s income:

i. Allowance for the needs of the waiver participant <i>(select one):</i>			
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>		
<input type="radio"/>	<input type="radio"/>	SSI standard	
<input type="radio"/>	<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons <i>(select one):</i>		
<input type="radio"/>	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	<input type="radio"/>	%	A percent of the FBR, which is less than 300%
<input type="radio"/>	<input type="radio"/>	\$	A dollar amount which is less than 300%.
<input type="radio"/>	<input type="radio"/>	%	A percentage of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):		
<input type="radio"/>			
<input type="radio"/>	The following dollar amount	\$	If this amount changes, this item will be revised.
	Specify dollar amount:		
<input type="radio"/>	The following formula is used to determine the needs allowance:		
	<i>Specify:</i>		
<input type="radio"/>	Other (specify):		
ii. Allowance for the spouse only <i>(select one):</i>			
<input type="radio"/>	Not Applicable		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	<i>Specify:</i>		
	Specify the amount of the allowance:		
<input type="radio"/>	<input type="radio"/>	SSI standard	
<input type="radio"/>	<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
	Specify dollar amount:		

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<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i>
iii. Allowance for the family (<i>select one</i>):	
<input type="radio"/>	Not applicable (see instructions)
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> The amount specified cannot exceed the higher of the Specify dollar amount: need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i>
<input type="radio"/>	Other (<i>specify</i>):
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.	
Select one:	
<input type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):

c-2. Regular Post-Eligibility Treatment of Income: 209(B) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):	
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>)
<input type="radio"/>	The following standard under 42 CFR §435.121

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	<i>Specify:</i>		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>)		
<input type="radio"/>	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	<input type="radio"/>	%	A percentage of the FBR, which is less than 300%
<input type="radio"/>	<input type="radio"/>	\$	A dollar amount which is less than 300% of the FBR
<input type="radio"/>	<input type="radio"/>	%	A percentage of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (<i>specify</i>):		
<input type="radio"/>	The following dollar amount Specify dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance: <i>Specify:</i>		
<input type="radio"/>	Other (<i>specify</i>):		
ii. Allowance for the spouse only (<i>select one</i>):			
<input type="radio"/>	Not applicable		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: <i>Specify:</i>		
	Specify the amount of the allowance:		
<input type="radio"/>	<input type="radio"/>	The following standard under 42 CFR §435.121: <i>Specify:</i>	
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <i>Specify</i>		

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iii. Allowance for the family <i>(select one)</i>		
	Not applicable (see instructions)	
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount: \$ <input type="text"/>	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <input type="text"/>	
<input type="radio"/>	Other (specify): <input type="text"/>	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
<input type="radio"/>	Not applicable <i>(see instructions)</i> Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.	
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State establishes the following reasonable limits <i>(specify)</i> : <input type="text"/>	

State:	
Effective Date	

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant		
<i>(select one):</i>		
<input type="radio"/>	SSI Standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons	
<input type="radio"/>	%	Specify percentage:
<input type="radio"/>	The following dollar amount:	\$ _____ If this amount changes, this item will be revised
<input type="radio"/>	The following formula is used to determine the needs allowance:	
	<i>Specify formula:</i>	
<input type="radio"/>	Other	
	<i>Specify:</i>	
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.		
Select one:		
<input type="radio"/>	Allowance is the same	
<input type="radio"/>	Allowance is different.	
	<i>Explanation of difference:</i>	
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.		
Select one:		
<input type="radio"/>	Not applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.	
<input type="radio"/>	The State does not establish reasonable limits.	

State:	
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<input type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.
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e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018

The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):		
<input type="radio"/>	The following standard included under the State plan (select one)	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons (select one):	
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	%	A percent of the FBR, which is less than 300%
<input type="radio"/>	\$	A dollar amount which is less than 300%.
<input type="radio"/>	%	A percentage of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):	
<input type="radio"/>	The following dollar amount	\$ _____ If this amount changes, this item will be revised.
<input type="radio"/>	Specify dollar amount:	
<input checked="" type="radio"/>	The following formula is used to determine the needs allowance: <i>Specify:</i>	
	The needs allowance for the waiver participant is 100% of the HHS Poverty Guidelines for one person plus an amount of earned income up to the substantial gainful activity level of earnings defined in Section 223(d)(4) of the Social Security Act. If dependent family members live in a community setting, the State will recognize that expenses may be higher due to the waiver client incurring additional costs related to supporting the dependent family members. An allowance may be deducted when making the eligibility determination in consideration of these additional expenses. This additional allowance is the difference between the allowance for a family member defined in Section 1924(d)(1)(C) of the Social Security Act and the allowance for a family member defined in 42 CFR 435.726(c)(3).	
<input type="radio"/>	Other (specify):	
ii. Allowance for the spouse only (select one):		
<input checked="" type="radio"/>	Not Applicable	
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: <i>Specify:</i>	
	Specify the amount of the allowance:	

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<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$ <input type="text"/> If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i>	
	<input type="text"/>	
iii. Allowance for the family (select one):		
<input type="radio"/>	Not applicable (see instructions)	
<input type="radio"/>	AFDC need standard	
<input checked="" type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$ <input type="text"/> The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i>	
	<input type="text"/>	
<input type="radio"/>	Other (<i>specify</i>):	
	<input type="text"/>	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.		
Select one:		
<input type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.</i>	
<input type="radio"/>	The State does not establish reasonable limits.	
<input checked="" type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):	
	The limits specified in Utah's Title XIX state plan for post-eligibility income deductions under 42 CFR 435.725, 435.726, 435.832 and Sec. 1924 of the Social Security Act. The limits are defined on supplement 3 to attachment 2.6A.	

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018

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i. Allowance for the needs of the waiver participant (<i>select one</i>):			
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>)		
<input type="radio"/>	The following standard under 42 CFR §435.121 <i>Specify:</i>		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>)		
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)		
<input type="radio"/>	%	A percentage of the FBR, which is less than 300%	
<input type="radio"/>	\$	A dollar amount which is less than 300% of the FBR	
<input type="radio"/>	%	A percentage of the Federal poverty level	
<input type="radio"/>	Other standard included under the State Plan (<i>specify</i>):		
<input type="radio"/>	The following dollar amount	\$	If this amount changes, this item will be revised.
<input type="radio"/>	Specify dollar amount:		
<input type="radio"/>	The following formula is used to determine the needs allowance: <i>Specify:</i>		
<input type="radio"/>	Other (<i>specify</i>):		
ii. Allowance for the spouse only (<i>select one</i>):			
<input type="radio"/>	Not applicable		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: <i>Specify:</i>		
<input type="radio"/>	Specify the amount of the allowance:		
<input type="radio"/>	The following standard under 42 CFR §435.121: <i>Specify:</i>		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	Specify dollar		

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	amount:		
<input type="radio"/>	The amount is determined using the following formula: <i>Specify</i>		
iii. Allowance for the family (<i>select one</i>)			
	Not applicable (see instructions)		
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount: \$		The amount specified cannot exceed the higher Specify dollar amount:
	of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.		
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Other (specify):		
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:			
a. Health insurance premiums, deductibles and co-insurance charges			
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>			
<input type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.</i>		
<input type="radio"/>	The State does not establish reasonable limits.		
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):		

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g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant		
<i>(select one):</i>		
<input type="radio"/>	SSI Standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons	
<input type="radio"/>	%	Specify percentage:
<input type="radio"/>	The following dollar amount:	\$ _____ If this amount changes, this item will be revised
<input checked="" type="radio"/>	The following formula is used to determine the needs allowance:	
	<i>Specify formula:</i>	
	The needs allowance for the waiver participant is 100% of the HHS Poverty Guidelines for one person plus an amount of earned income up to the substantial gainful activity level of earnings defined in Section 223(d)(4) of the Social Security Act. If dependent family members live in a community setting, the State will recognize that expenses may be higher due to the waiver client incurring additional costs related to supporting the dependent family members. An allowance may be deducted when making the eligibility determination in consideration of these additional expenses. This additional allowance is the difference between the allowance for a family member defined in Section 1924(d)(1)(C) of the Social Security Act and the allowance for a family member defined in 42 CFR 435.726(c)(3).	
<input type="radio"/>	Other	
	<i>Specify:</i>	
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.		
Select one:		
<input checked="" type="radio"/>	Allowance is the same	
<input type="radio"/>	Allowance is different.	
	<i>Explanation of difference:</i>	
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:		

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- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

<input type="radio"/>	Not applicable (see instructions) <i>Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input checked="" type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

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Appendix B-6: Evaluation / Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State’s policies concerning the reasonable indication of the need for waiver services:

i.	Minimum number of services.	The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:
	1	
ii.	Frequency of services.	The State requires (select one):
<input checked="" type="checkbox"/>	The provision of waiver services at least monthly	
<input type="checkbox"/>	Monthly monitoring of the individual when services are furnished on a less than monthly basis	If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

<input type="checkbox"/>	Directly by the Medicaid agency	
<input checked="" type="checkbox"/>	By the operating agency specified in Appendix A	
<input type="checkbox"/>	By an entity under contract with the Medicaid agency.	Specify the entity:
<input type="checkbox"/>	Other	Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing initial level of care evaluations will be Utah licensed registered nurses employed by DSPD.
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- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Utah Administrative Code R414-502 defines the State's level of care for NF care. The rule defines that a client must meet two of the following three criteria (specifically criteria 1 and 3 below for participants of the PD Waiver):

- (1) Due to diagnosed medical conditions, the applicant requires substantial physical assistance with daily living activities above the level of verbal prompting, supervising, or setting up;
- (2) The attending physician has determined that the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through a Medicaid Home and Community- Based Waiver program; or
- (3) The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting, or without the services and supports of a Medicaid Home and Community- Based Waiver program.

DSPD will conduct evaluation and reevaluation assessments using the standard waiver instrument, InterRAI MINIMUM DATA SET – HOME CARE (MDS-HC) as described in Appendix B-6(e), to assess level of care.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

<input type="radio"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input checked="" type="radio"/>	<p>A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.</p> <p>Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.</p> <p>The InterRAI MINIMUM DATA SET - HOME CARE (MDS-HC) is the instrument used to determine the level of care for this waiver. Persons responsible for collecting the needed information and for making level of care determinations are staff from DSPD trained in the proper application of the MDS-HC instrument and the proper analysis of the MDS-HC data to perform level of care evaluations.</p> <p>The MDS-HC is a comprehensive, standardized instrument for evaluating the needs, strengths and preferences of clients served by home care agencies. The MDS-HC also acts as a screening component that enables a home care provider to assess multiple key domains of function, health, social support and service use. Particular MDS-HC items identify clients who could benefit from further evaluation of specific problems and risk for functional decline. The MDS-HC has been designed to be compatible with the family of InterRAI assessment and problem identification tools which includes the MDS (InterRAI Minimum Data Set) nursing home assessment instrument. Such compatibility promotes continuity of care through a seamless geriatric assessment system across multiple health care settings and promotes a person-centered evaluation</p>

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in contradiction to a site-specific assessment.

Accordingly, the main differences between the MDS-HC and the MDS is that the MDS includes assessment information more pertinent to a residential facility setting, addressing structural problems related to performance of ADLs (Activities of Daily Living) in a facility, activity pursuit patterns, discharge potential and overall status and therapy supplement. Whereas the MDS-HC includes assessment information more pertinent to community living by addressing social functioning, informal support services, preventative health measures, environmental assessment, service utilization of home care services, medications (prescription, non-prescription and herbal), resource/support and services assessment and information, social resource assessment, caregiver assessment, social support information, additional medical problems and nurse summary sections.

Despite these differences, both the MDS-HC and MDS assessments help to determine level of care by including basic assessment data related to the individual. This information includes: identification and background information, cognitive patterns, communication/hearing patterns, vision patterns, mood and behavior patterns, physical functioning [Instrumental Activities of Daily Living (IADLs) and ADLs performance], continence, disease diagnoses, health conditions, nutrition/hydration status, skin condition, special treatments and therapies and programs.

- f. **Process for Level of Care Evaluation/Reevaluation.** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

DSPD utilizes the following process to make level of care determinations as follows:

The registered nurse employed by DSPD will conduct a face to face level of care assessment using the standard waiver instrument described in Appendix B-6(e). This assessment is conducted at the individual's current living environment.

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input type="radio"/>	Every twelve months
<input checked="" type="radio"/>	Other schedule <i>Specify the other schedule:</i>
	A full level of care reevaluation will be completed at a minimum of annually (no later than by the end of the calendar month of the last level of care evaluation, one year later).
	A Health Status Screening must be performed (either by phone or in person) by the administrative case manager at any time a participant has experienced a significant change in health status and at the conclusion of all inpatient stays in a medical institution to determine whether the participant's health status indicates that:
	1) The participant's needs can continue to be safely met within the scope of the PD Waiver program; and
	2) The participant continues to meet NF level of care.

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	<p>If during the Health Status Screening it becomes evident that the participant’s mental or physical condition has changed significantly, a new level of care reevaluation must be performed in person.</p> <p>The administrative case manager will document the Health Status Screening date and determination in the participant’s activity log in USTEPS.</p>
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h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (*select one*):

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="radio"/>	<p>The qualifications are different.</p> <p><i>Specify the qualifications:</i></p>

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

<p>USTEPS, developed and maintained by DSPD, creates an automated tickler “to do” message that is sent at the beginning of the month in which a reevaluation is due.</p>
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j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

<p>Electronically retrievable documentation of all evaluations and reevaluations are maintained within USTEPS.</p> <p>To assure documents are retrievable, standard data back-up procedures employed within the UTSTEPS database include:</p> <ul style="list-style-type: none"> •The DSPD_USTEPS_PROD_DB is backed up from Sybase database to a disk dump at 10:30 PM every night. <p>The Uniplexed Information and Computing System (UNIX) backup occurs on the following schedule (these are backups to tape):</p> <ul style="list-style-type: none"> • Monthly Full on 1st of each month, copies are retained on and off site for 3 years.
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Quality Improvement: Level of Care

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

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a. Methods for Discovery: **Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

- i. *Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #1	Number and percentage of new participants admitted to the PD Waiver that have been determined to meet NF Level of Care (LOC) prior to admission to the waiver. Numerator = the number of new participants that were determined to meet NF LOC prior to admission to the waiver; Denominator = the total number of new participants admitted to the waiver.		
Data Source • USTEPS	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample;
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that	Frequency of data aggregation and analysis: (check each that	

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	<i>applies</i>	<i>applies</i>	
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input type="checkbox"/> <i>Other: Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	
		<input type="checkbox"/> <i>Other: Specify:</i>	

ii. **Sub-assurance:** *The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #1	Number and percentage of Health Status Screenings conducted when a significant change in health status occurs and/or at the conclusion of an inpatient stay in a medical institution to determine an ongoing need for NF LOC. Numerator = # of events in compliance; Denominator = total # of events requiring a Health Status Screening.		
Data Source • USTEPS	Responsible Party for data collection/generation <i>(check each that applies)</i>	Frequency of data collection/generation: <i>(check each that applies)</i>	Sampling Approach <i>(check each that applies)</i>
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error</i>
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input checked="" type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i>

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		<i>Other: Specify:</i>	
			<input type="checkbox"/> <i>Other: Describe DSPD:</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input type="checkbox"/> <i>Other: Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	
		<i>Other: Specify:</i>	

Performance Measure: #2	Number and percentage of events when a LOC is reevaluated at the time a significant change in health status occurs to determine if the individual continues to meet NF LOC, when the Screening dictates one was required. The numerator is the number of events in compliance; the denominator is the total number of events that occurred during the review period.		
Data Source • USTEPS	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error</i>
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input checked="" type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i>
		<i>Other: Specify:</i>	
			<input type="checkbox"/> <i>Other: Describe</i>

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			DSPD:
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

Performance Measure: #3	Number and percentage of LOC initial evaluations and reevaluations conducted by a licensed Utah Registered Nurse (RN). The numerator is the number of LOC initial evaluations and reevaluations which were performed by a licensed Utah RN; the denominator is the total number of LOC initial evaluations and reevaluations performed and reviewed.		
Data Source • USTEPS	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe DSPD:
Data Aggregation	Responsible Party for data aggregation and	Frequency of data aggregation and	

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and Analysis	analysis (check each that applies)	analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

Performance Measure: #4	Number and percentage of LOC reevaluations conducted during a face to face visit. The numerator is the number of LOC reevaluations that were conducted during a face to face visit with the participant; the denominator is the total number of LOC reevaluations reviewed.		
Data Source • USTEPS	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		Other: Specify:	
			<input type="checkbox"/> Other: Describe DSPD:
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

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	<input type="checkbox"/> Other: Specify:	X Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		Other: Specify:	

iii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Individuals who request services from DSPD through the PD Waiver are screened for level of care and then ranked according to a critical needs assessment process and placed on the waiting list. When the individual is taken off of the waiting list, the administrative case manager determines if the individual needs services from the PD Waiver program. For all individuals who have been taken off of the waiting list and require services, an evaluation for level of care is conducted by the administrative case manager. DSPD is the entity that will conduct level of care reviews. Issues regarding the accuracy of level of care determinations are addressed and corrected immediately by DSPD.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Individual issues regarding the accuracy of level of care determination are addressed and corrected immediately by DSPD to assure that all participants meet NF level of care. Plans of correction which include additional training may be required to assure future compliance. To assure all issues have been addressed, DSPD is required to report back to the SMA on the results of their interventions within the time frame stipulated in standard operating procedures and protocols or are stipulated on a case by case basis depending on the nature of a specific issue. Results of the reviews will be documented in the SMA Final Report.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)

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	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
	<input type="checkbox"/> <i>Other: Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>
		<input type="checkbox"/> <i>Continuously and Ongoing</i>
		<input type="checkbox"/> <i>Other: Specify:</i>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

<input type="radio"/>	Yes <i>(complete remainder of item)</i>
<input checked="" type="radio"/>	No

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
 - ii. given the choice of either institutional or home and community-based services.
- a. Procedures.** Specify the State’s procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Freedom of Choice is documented in the Person Centered Support Plan (PCSP).

Freedom of choice procedures:

1. When an individual is determined eligible for waiver services, the individual and the individual’s representative, if applicable, will be informed of the alternatives available under the waiver programs and offered the choice of institutional care (NF) or home and community-based care. A copy of the DSPD publication AN INTRODUCTORY GUIDE-Division of Services for People with Disabilities (Guide), which describes the array of services and supports available in Utah including NFs and the HCBS waiver programs, is given to each individual applying for waiver services.
2. The administrative case manager will offer the choice of waiver services only if:
 - a. The individual's needs assessment indicates the services the individual requires, including waiver services, are available in the community.
 - b. The individual support plan has been agreed to by all parties.
 - c. The health and safety of the individual can be adequately protected in relation to the delivery of waiver services and supports.
3. Once the individual has chosen home and community-based waiver services, the choice has been documented by the administrative case manager and the individual has received a copy of the Guide, subsequent review of choice of program will only be required at the time a substantial change in the enrollee’s condition results in a change in the PCSP. It is, however, the individual’s option to choose institutional (NF) care at any time during the period they are in the waiver.
4. The waiver enrollee will be given the opportunity to choose the providers of waiver services identified on the PCSP if more than one qualified provider is available to render the services. The individual’s choice of providers will be documented in the PCSP.
5. The agency will provide an opportunity for a fair hearing in writing, under 42 CFR Part 431, subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to the institutional care specified for this request, who are denied the waiver service(s) and/or waiver provider(s) of their choice, who are found ineligible for a waiver program or who have been notified of actions to suspend, reduce and/or terminate services.

- b. Maintenance of Forms.** Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Freedom of Choice is documented in the PCSP as part of the person centered support planning process

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and is maintained electronically by DSPD in the individual's case record within USTEPS.

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Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003):

Medicaid providers are required to provide foreign language interpreters for Medicaid clients who have limited English proficiency. Waiver clients are entitled to the same access to an interpreter to assist in making appointments for qualified procedures and during those visits. Providers must notify clients that interpretive services are available at no charge. The State Medicaid Agency encourages clients to use professional services rather than relying on a family member or friend though the final choice is theirs. Using an interpretive service provider ensures confidentiality as well as the quality of language translation.

Information regarding access to Medicaid Translation Services is included in the Medicaid Member Guide distributed to all Utah Medicaid recipients. Eligible individuals may access translation services by calling the Medicaid Helpline.

For the full text of the Medicaid Member Guide, go to:
http://health.utah.gov/umb/forms/pdf/Medicaid_Member_Guide.pdf

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Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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:*

Statutory Services (check each that applies)		
Service	Included	Alternate Service Title (if any)
Case Management	<input type="checkbox"/>	
Homemaker	<input type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	X	Personal Attendant Services
Adult Day Health	<input type="checkbox"/>	
Habilitation	<input type="checkbox"/>	
Residential Habilitation	<input type="checkbox"/>	
Day Habilitation	<input type="checkbox"/>	
Prevocational Services	<input type="checkbox"/>	
Supported Employment	<input type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input type="checkbox"/>	
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input type="checkbox"/>	
Other Services (select one)		
<input type="radio"/>	Not applicable	
X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (<i>list each service by title</i>):	
a.	Personal Emergency Response System (purchase, testing, installation and service fees)	
b.	Specialized Medical Equipment and Supplies - Monthly Fee	

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c.	Specialized Medical Equipment and Supplies - Purchase, Installation, Removal, Replacement and Repair		
d.			
Extended State Plan Services (<i>select one</i>)			
X	Not applicable		
O	The following extended State plan services are provided (<i>list each extended State plan service by service title</i>):		
a.			
b.			
c.			
Supports for Participant Direction (<i>check each that applies</i>)			
<input type="checkbox"/>	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.		
X	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.		
O	Not applicable		
	Support	Included	Alternate Service Title (if any)
	Information and Assistance in Support of Participant Direction	<input type="checkbox"/>	
	Financial Management Services	X	
Other Supports for Participant Direction (<i>list each support by service title</i>):			
a.			
b.			
c.			

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C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification				
Personal Attendant Services				
Category 1:	Sub-Category 1:			
Category 2:	Sub-Category 2:			
Category 3:	Sub-Category 3:			
Category 4:	Sub-Category 4:			
Service Definition (Scope):				
<p>Personal Attendant Services are essential to help the waiver participant achieve maximum independence and may vary depending on the needs of the individual and their daily schedule. Services may include: (a) hands-on care consisting of both a non-skilled medical and non-medical supportive nature specific to the needs of a medically stable individual with physical disabilities. Such support may involve assistance to the participant in performing all Activities of Daily Living (ADLs) to include but not limited to bathing, dressing, toileting, transferring and maintaining continence. Any skilled medical care and health maintenance required as part of the participant’s ADLs may also be provided but only as permitted by State law and as certified by the participant’s physician; (b) assistance with all Instrumental Activities of Daily Living (IADLs) to include housekeeping, chore services, meal preparation, grocery shopping, using the telephone, personal hygiene and all other reasonable and necessary activities which are incidental to the performance of the participant’s care may additionally be furnished as part of this service when agreed upon by the participant, personal attendant and the case manager, as outlined in the Person Centered Support Plan (PCSP). Payment to parents or step-parents can be made for personal attendant services deemed as extraordinary and as outlined in appendix C-2(e).</p>				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
<p>Limitations: Limits on the amount, frequency and/or duration are specified in the PCSP and based upon assessed need. Personal Attendant services are rendered in 15 minute units or at a daily rate. All instances in which Personal Attendant services are delivered for a period of eight hours or more within a day shall be billed using a daily rate rather than hourly rates for this service.</p> <p>Transportation costs associated with the provision of care as outlined above through this service may not be included in the scope of Personal Attendant Services.</p>				
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian
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Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
	Qualified individual selected by the participant who has a joint DSPD contract/Medicaid Provider Agreement* * All providers receiving state funds appropriated to DSPD are required to enter into a state contract with the DSPD as a provider of services to persons with disabilities. The DSPD state contract is a document separate from the Medicaid Provider Agreement negotiated between each waiver provider and the SMA. A joint DSPD state contract/SMA Provider Agreement is in place for this service.			

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual Personal Attendant		Home Health Aide Certificate of Completion (R432-700-22) OR OTHER STANDARD	Be at least 18 years of age; have a Social Security Number and provide verification of such; agree to have a Criminal Background Check; have the ability to read, understand and carry out written and verbal instructions, write simple clinical notes and record messages; be trained in First Aid; be oriented and trained in all aspects of care to be provided to the participant including medical care and health maintenance; be able to demonstrate competency in all areas of responsibility.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Attendant	Division of Services for People with Disabilities' waiver recipient	Prior to the delivery of Medicaid Personal Attendant Services

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Service Specification

Personal Emergency Response Systems (PERS)

Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope):

Personal Emergency Response Systems serve the purpose of enabling the individual who has the skills to live independently or with minimal support to summon assistance in case of an emergency.

Personal Emergency Response Systems involve electronic devices of a type that allows the individual requiring such a system to rapidly secure assistance in the event of an emergency. The device may be any one of a number of such devices but must be connected to a signal response center that is staffed twenty-four hours a day, seven days a week, by trained professionals.

Elements of Personal Emergency Response Systems:

- ❖ Personal Emergency Response Systems (PERS) Response Center Service
 - Provides ongoing access to a signal response center that is staffed twenty-four hours per day, seven days a week by trained professionals responsible for securing assistance in the event of an emergency.
- ❖ Personal Emergency Response Systems (PERS) Purchase, Rental & Repair
 - Provides an electronic device of a type that allows the individual to summon assistance in an emergency. The device may be any one of a number of such devices but must be connected to a signal response center.
- ❖ Personal Emergency Response Systems (PERS) Installation, Testing & Removal
 - Provides installation, testing, and removal of the PERS electronic device by trained personnel.

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

Limitations: PERS services are limited to those individuals who live alone, live with others who are not capable of responding in an emergency or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	X	Provider managed
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Specify whether the service may be provided by (<i>check each that applies</i>):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) (<i>check one or both</i>):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Personal Emergency Response System suppliers and response centers.

Provider Qualifications

Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Personal Emergency Response System suppliers and response centers	Current business license		Emergency Response System Supplier - FCC registration of equipment placed in individual's home. Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Personal Emergency Response System Installer - Demonstrated ability to properly install and test specific equipment being handled. Personal Emergency Response Center - 24 hour per day operation, 7 days per week. All Providers - Medicaid provider enrolled to provide personal emergency response system services.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Emergency Response Systems	Division of Services for People with Disabilities	Upon initial enrollment and annually thereafter

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Service Specification				
Specialized Medical Equipment and Supplies – Purchase, Installation, Removal, Replacement and Repair				
Category 1:	Sub-Category 1:			
Category 2:	Sub-Category 2:			
Category 3:	Sub-Category 3:			
Category 4:	Sub-Category 4:			
Service Definition (Scope):				
<p>Specialized Medical Equipment and Supplies – Purchase, Installation, Removal, Replacement and Repair includes the purchase of automated medication dispensary devices as well as the installation, removal, replacement and repair of these devices. This service also covers the training of participants or caregivers in the operation and/or maintenance of the equipment.</p> <p>Automated medication dispensary devices consist of timed alarmed monitoring systems that have the ability to store and dispense proper dosages of medications at scheduled times as prescribed by the person’s medical practitioner(s). Medication dispensary devices reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and must be of direct medical or remedial benefit to the participant. Medication dispensary devices shall only be an option when more simple methods of medication reminders are determined to be ineffective by the operating agency, must be specified in the individual’s PCSP and must also meet applicable standards of manufacture, design and installation.</p>				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
<p>Limitations: Expenditures for specialized medical equipment and the supplies necessary to operate that equipment will be in accordance with Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and supplies necessary for the operation of that equipment must be approved prior to purchase by an administrative case manager.</p> <p>An administrative case manager may only authorize the purchase, installation, removal, replacement and/or repair of the equipment allowed under this service after making a determination that the State plan will not cover the same or similar equipment and/or services.</p>				
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian
Provider Specifications				
Provider Category(s) <i>(check one or</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
	Automated Medication Dispensary Equipment and Supply Suppliers			

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<i>both</i>):		

Provider Qualifications

Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Specialized Medical Equipment and Supplies Supplier Personal Attendant	Current business license		FCC registration of equipment placed in individual's home. Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider. Automated Medication Dispensary Device Installer - Demonstrated ability to properly install and test specific equipment being handled.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Specialized Medical Equipment and Supplies Supplier	Division of Services for People with Disabilities	Annually

Service Specification

Specialized Medical Equipment and Supplies – Monthly Fee

Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:

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Category 4:	Sub-Category 4:		
Service Definition (Scope):			
<p>Specialized Medical Equipment and Supplies - Monthly Fee includes periodic service (e.g., monthly) fees for ongoing support services and/or rental associated with automated medication dispensary devices. Automated medication dispensary devices consist of timed alarmed monitoring systems that have the ability to store and dispense proper dosages of medications at scheduled times as prescribed by the person's medical practitioner(s).</p> <p>Periodic service fees associated with medication dispensary devices that are reimbursed with waiver funds are in addition to any medical equipment fees furnished under the State plan and must be in association with medication dispensary devices which provide a direct medical or remedial benefit to the participant. Additionally, periodic service fees associated with medication dispensary devices must be specified in the individual's PCSP</p> <p>Specialized Medical Equipment and Supplies - Monthly Fee will not include the costs of maintenance and upkeep of equipment as this is covered under the Specialized Medical Equipment and Supplies – Purchase, Installation, Removal, Replacement and Repair service.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
<p>Limitations: Expenditures for specialized medical equipment and the supplies necessary to operate that equipment will be in accordance with Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and supplies necessary for the operation of that equipment must be approved prior to purchase by an administrative case manager.</p> <p>An administrative case manager may only authorize the periodic service fees associated with medication dispensary devices allowed under this service after making a determination that the State plan will not cover the same or similar equipment fees.</p>			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/> Participant-directed as specified in Appendix E <input checked="" type="checkbox"/> Provider managed		
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian		
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:	
		Automated Medication Dispensary Equipment and Supply Suppliers	
Provider Qualifications			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Specialized Medical Equipment and Supplies Supplier	Current business license		FCC registration of equipment placed in individual's home. Enrolled with DSPD as an authorized

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			provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Specialized Medical Equipment and Supplies Supplier	Division of Services for People with Disabilities	Annually

Service Specification	
Financial Management Services	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope):	
<p>Financial Management Services are offered in support of the self-administered services delivery option. Services rendered under this definition include those to facilitate the employment of personal attendants or assistants by the individual or designated representative including:</p> <ul style="list-style-type: none"> a) Provider qualification verification; b) Employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports; c) Medicaid claims processing and reimbursement distribution, and d) Providing monthly accounting and expense reports to the participant and to the Division of Services for People with Disabilities (DSPD). 	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

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Service Delivery Method <i>(check each that applies):</i>					<input type="checkbox"/>	Participant-directed as specified in Appendix E		<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>			<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian	
Provider Specifications									
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:			<input checked="" type="checkbox"/>	Agency. List the types of agencies:			
					Licensed Public Accounting Agency				
Provider Qualifications									
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>						
Financial Management Services	Certified Public Accountant Sec 58-26A, UCA And R156-26A, UAC	Certified by the SMA as an authorized provider of services and supports	<ul style="list-style-type: none"> • Under State contract with the SMA as an authorized provider of services and supports. • Comply with all applicable State and local licensing, accrediting and certification requirements. • Understand the laws, rules and conditions that accompany the use of State and local resources and Medicaid resources. • Utilize accounting systems that operate effectively on a large scale as well as track individual budgets. • Utilize a claims processing system acceptable to the SMA. • Establish time lines for payments that meet individual needs within DOL standards. • Generate service management, and statistical information and reports as required by the Medicaid program. • Develop systems that are flexible in meeting the changing circumstances of the Medicaid program. • Provide needed training and technical assistance to participants, their representatives and others. • Document required Medicaid provider qualifications and enrollment requirements and maintain results in provider/employee file. 						

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			<ul style="list-style-type: none"> • Act on behalf of the person receiving supports and services for the purpose of payroll reporting. • Develop and implement an effective payroll system that addresses all related tax obligations. • Make related payments as approved in the person’s budget, authorized by the administrative case manager. • Generate payroll checks in a timely and accurate manner and in compliance with all Federal and State regulations pertaining to “domestic service” workers. • Conduct background checks as required and maintain results in employee file. • Process all employment records. • Obtain authorization to represent the individual/person receiving supports. • Prepare and distribute an application package of information that is clear and easy for the individuals hiring their own staff to understand and follow. • Establish and maintain a record for each employee and process the employee employment application package and documentation. • Utilize an accounting information system to invoice and receive Medicaid reimbursement funds. • Utilize an accounting and information system to track and report the distribution of Medicaid reimbursement funds. • Generate a detailed Medicaid reimbursement funds distribution report to the individual participant or representative semi-annually. • Withhold, file and deposit FICA, FUTA and SUTA taxes in accordance with IRS, DOL and State rules. • Generate and distribute IRS W-2’s, Wage and Tax Statements and related documentation annually to all support workers who meet the statutory threshold earnings amounts during the
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			<p>tax year by January 31st.</p> <ul style="list-style-type: none"> • File and deposit Federal and State income taxes in accordance with IRS, State rules and regulations. • Assure that employees are paid established unit rates in accordance with Federal and State Fair Labor Standards Acts (FLSA). • Process all judgments, garnishments, tax levies or any related holds on an employee's funds as may be required by local, State or Federal laws. • Distribute, collect and process all employee time sheets as summarized on payroll summary sheets completed by the person or his/her representative. • Prepare employee payroll checks, at least monthly, sending them directly to the employees. • Keep abreast of all laws and regulations relevant to the responsibilities it has undertaken with regard to the required Federal and State filings and the activities related to being a Fiscal/Employer Agent. • Establish a customer service mechanism in order to respond to calls from individuals or their representative employers and workers regarding issues such as withholding and net payments, lost or late checks, reports and other documentation. • Customer service representatives are able to communicate effectively in English and Spanish by voice and TTY with people who have a variety of disabilities. • Have a Disaster Recovery Plan for restoring software and master files and hardware backup if management information systems are disabled so that payroll and invoice payment systems remain intact. • Regularly file and perform accounting auditing to ensure system accuracy and compliance with general accounting practice.
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Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Financial Management Services	Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services	Upon initial enrollment and annually thereafter	

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○	Not applicable – Case management is not furnished as a distinct activity to waiver participants.
X	Applicable – Case management is furnished as a distinct activity to waiver participants. Check each that applies:
<input type="checkbox"/>	As a waiver service defined in Appendix C-3 (<i>do not complete C-1-c</i>)
<input type="checkbox"/>	As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
X	As an administrative activity. <i>Complete item C-1-c.</i>

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Administrative case managers employed by DSPD.

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Appendix C-2: General Service Specifications

- a. Criminal History and/or Background Investigations.** Specify the State’s policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-(*select one*):

<input checked="" type="radio"/>	<p>Yes. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):</p> <p>UCA 62A-2-120 and R501-14, of the Utah Human Services Administration, require all persons having direct access to children or vulnerable adults to undergo a criminal history/background investigation.</p> <p>The Office of Licensing, an agency within the Utah Department of Human Services, has the responsibility of conducting background checks on all direct care workers who provide waiver services. The scope of the investigation includes a check of the State’s child and adult abuse registries (maintained by The Utah Division of Child and Family Services and The Utah Division of Aging and Adult Services respectively), and a Criminal History check through the Criminal Investigations and Technical Services Division of the Department of Public Safety. If a person has lived outside the State of Utah or in any foreign countries for six or more consecutive weeks within the last five years, the FBI National Criminal History Records and National Criminal History will be accessed to conduct a check in those states and countries where the person resided. The Division of Services for People with Disabilities (DSPD) maintains a database on all approved employees. DSPD will not approve payments if the required screenings have not been completed.</p> <p>For providers under the Self-Administered Service Model, the state will withhold payments for services for anyone who has not completed a background check within the first 30 days of being hired. The Division of Services for People with Disabilities (DSPD) has the ability to view the database of the Office of Licensing in regards to the status of employees hired under the self-administered model. All employees are required to renew their background checks on an annual basis.</p> <p>The health and safety of participants are ensured by routinely scheduled face-to-face visits by support coordinators and by quality monitoring reviews performed by both DSPD and the SMA.</p>
<input type="radio"/>	<p>No. Criminal history and/or background investigations are not required.</p>

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):

<input checked="" type="radio"/>	<p>Yes. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):</p>
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	<p>UCA 62A-2-121 through 122 and R501-14, of the Utah Human Services Administration, require all persons having direct access to children or vulnerable adults to undergo an abuse screening. The Utah Division of Aging and Adult Services and The Utah Division of Child and Family Services maintain these abuse registries.</p> <p>A designated staff person within the Department of Human Services, Office of Licensing, completes all screenings. The Division of Services for People with Disabilities (DSPD) maintains a database on all approved employees. DSPD will not approve payments if the required screenings have not been completed.</p>
<input type="radio"/>	No. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

<input checked="" type="checkbox"/>	No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i>
<input type="checkbox"/>	Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Complete Items C-2-c.i – c.iii.</i>

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

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ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

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iii. Scope of Facility Standards. For this facility type, please specify whether the State’s standards address the following (*check each that applies*):

Standard	Topic Addressed
Admission policies	<input type="checkbox"/>
Physical environment	<input type="checkbox"/>
Sanitation	<input type="checkbox"/>
Safety	<input type="checkbox"/>
Staff : resident ratios	<input type="checkbox"/>
Staff training and qualifications	<input type="checkbox"/>
Staff supervision	<input type="checkbox"/>
Resident rights	<input type="checkbox"/>
Medication administration	<input type="checkbox"/>
Use of restrictive interventions	<input type="checkbox"/>
Incident reporting	<input type="checkbox"/>
Provision of or arrangement for necessary health services	<input type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

<input checked="" type="radio"/>	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="radio"/>	Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of <i>extraordinary care</i> by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</i>

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

<input type="radio"/>	The State does not make payment to relatives/legal guardians for furnishing waiver services.
<input checked="" type="radio"/>	The State makes payment to relatives/legal guardians under <i>specific circumstances</i> and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
	The types of relatives to who payment is made: With the exception of parents and step-parents of adult children who are only allowed to be paid under specific circumstances, there are no restrictions to payments made to relatives of the participant. Specific circumstances under which payment is made to a parent and/or step-parent of the participant: 1. When a participant lives in a rural area within five miles of a population center of less than 2,500 and there are no other resources available to offer supports within a reasonable geographic area (15 miles) from the participant and the participant conducts an ongoing recruitment of resources other than a parent and/or step-parent; 2. When the parent and/or step-parent, who has specialized training for safely operating health related technology for the participant including but not limited to the operation of a ventilator, G peg tube feeding, home dialyses infusion and wound care, performs those tasks because the participant can demonstrate they have no other dependable or qualified resources

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	<p>available to do so;</p> <p>3. When the participant is functionally quadriplegic and is dependent on others to perform health and safety related supports and other routine ADLs; and/or</p> <p>4. When the participant needs supports critical to their health and safety during non-traditional work hours such as during the night.</p> <p>In all such instances, parents and/or step-parents may be paid to provide services under the PD Waiver through the Personal Attendant service.</p> <p>Controls that are employed to ensure that payments are made only for services rendered:</p> <p>In order for a parent and/or step parent to be paid under this waiver, he/she must meet all of the following authorization criteria and monitoring provisions:</p> <ul style="list-style-type: none"> - meet the criteria as outlined in the Personal Attendant Service; - the service must be specified in the participant's Person Centered Support Plan (PCSP); - service must be paid at a rate that does not exceed that which would otherwise be paid to an employee; and - time-sheets and other required documentation must be submitted for hours paid. <p>Other monitoring requirements/provisions:</p> <p>The below listed requirements apply to participants electing to use parents and/or step-parents to be paid during specific circumstances:</p> <ul style="list-style-type: none"> - monthly reviews by the FMS of hours billed for parents and/or step-parents care. These reviews will be overseen by the administrative case managers to ensure the appropriate usage and compliance with the billing process; -the administrative case manager will contact the participant by phone or e-mail on at least a quarterly basis to identify the proper usage of and compliance with the program and to also ensure the participant's health and safety as well as the status of the participant and if the specific circumstance still applies; and - the administrative case manager will conduct annual Self-Administered Services (SAS) reviews and will review all of the required SAS documentation.
<input type="radio"/>	<p>Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3. Specify the controls that are employed to ensure that payments are made only for services rendered.</p>
<input type="radio"/>	<p>Other policy. <i>Specify:</i></p>

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- f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All Participants in the PD Waiver Program operated by DSPD are allowed to hire, train and supervise their own employees who provide direct care services.

Participants with physical disabilities hire staff in accordance with Federal IRS and DOL rules and regulations (IRS Revenue Ruling 87-41; IRS Publication 15-A: Employer's Supplemental Tax Guide; FLSA Domestic Service Regulations in 29 CFR § 552.3).

The Utah Department of Health will enter into a provider agreement with all willing providers who are selected by the participant and meet licensure, certification and/or other competency requirements.

DHS/DSPD provides a participant with choices for a fiscal agent. The fiscal agent is a private or public entity that is approved by the IRS (see IRS Revenue Procedure 70-6, 1970-1 C.B. 420) to act as the client's intermediary for the purpose of managing employment taxes, including income tax withholding, FICA, FUTA/SUTA, and brokering/managing benefits, including worker's compensation and state disability insurance premiums (if applicable). The fiscal agent collects employment documents and verifies signatures from participants prior to distributing paychecks to the participant's employees. The participant remains the employer of record, retaining control over the hiring, training, management and supervision of employees hired by the participant who provide direct care services.

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. Methods for Discovery: **Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

- i. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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Performance Measure: #1	Number and percentage of PD Waiver providers who meet DSPD provider contract criteria. The numerator is the number of PD Waiver providers that, upon initial enrollment and annually thereafter, met all DSPD contract criteria; the denominator is the total number of providers.		
Data Source • USTEPS	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		Other: Specify:	

ii. **Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed

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statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #1	Number and percentage of PD Waiver participants who maintain accurate and updated Personal Attendant employee files. The numerator is the number of participants reviewed who are in compliance; the denominator is the total number of participants reviewed.		
Data Source • Employee Files	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		Other: Specify:	

iii. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

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For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #1	Number and percentage of PD Waiver participants who provided training to their Personal Attendant employees. The numerator is the total number of participants who upon review are determined to have trained their Personal Attendant employees; the denominator is the total number of participants reviewed.		
Data Source • USTEPS	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

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- iv. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

DSPD contract analysts conduct annual provider reviews of all programs that provide services to PD waiver participants. Monitoring includes all criteria specified in the provider contract. Administrative case managers monitor a sample of SAS employees on a monthly basis. The administrative case managers also complete a review checklist which covers employee files, forms and appropriate training for staff. Time sheets are reviewed to ensure proper billing for services. Administrative case managers meet in person with the participant to confirm the employees have received appropriate training. Both the administrative case managers and the Utah Systems for Tracking Eligibility, Planning and Services (USTEPS) system track the expenditures for each participant and ensure that services remain within the allotted budget.

b. Methods for Remediation/Fixing Individual Problems

- i. *Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

Individual provider issues identified either through contract reviews or monitoring of SAS, conducted by administrative case managers, are corrected immediately or, at a minimum, within designated time frames. To assure all issues have been addressed, DSPD is required to report back to the SMA on the results of their interventions within the time frame stipulated in standard operating procedures and protocols or are stipulated on a case by case basis depending on the nature of a specific issue. Results of the reviews will be documented in the SMA’s Final Report.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually

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		<input type="checkbox"/> <i>Continuously and Ongoing</i>
		<input type="checkbox"/> <i>Other: Specify:</i>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

<input type="radio"/>	Yes <i>(complete remainder of item)</i>
<input checked="" type="radio"/>	No

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*check each that applies*).

<input checked="" type="checkbox"/>	Not applicable – The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
<input type="checkbox"/>	Applicable – The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant’s services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant’s needs; and, (f) how participants are notified of the amount of the limit.

<input type="checkbox"/>	<p>Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. <i>Furnish the information specified above.</i></p>
<input checked="" type="checkbox"/>	<p>Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i></p> <p>Utilizing the score derived from the Personal Assistance Critical Needs Assessment and the needs identified in the InterRAI MINIMUM DATA SET - HOME CARE (MDS-HC), the administrative case manager estimates the participant’s prospective budget amount. These assessments function as a benchmark during the annual person centered planning process. The participant’s needs, amount, frequency and duration of available services are discussed with the participant. An individualized waiver services budget is agreed upon. The participant decides how the funds should be allocated among the waiver services.</p> <p>DSPD provides a central location for all administrative case managers in this waiver. These administrative case managers receive uniform training and engage in a cross review process thus assuring the budget process is applied consistently to all waiver participants across the state.</p> <p>The waiver participant may contact the administrative case manager at any time to request a change in services. The administrative case manager will review the request with the participant, and may conduct a new MDS-HC if the request is due to a significant change in the participant’s health status. The administrative case manager will present the reviewed request to the PD Waiver program manager for approval.</p> <p>If additional funding is approved, the administrative case manager notifies the participant and changes are made to the participant’s PCSP to reflect the funding allocation increase. If the request is denied, the participant receives a Notice of Agency Action and information relating to their hearing rights.</p>

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	<p>The process employed for determining individual budgets is open to public inspection during the development of the state implementation plan. During this time, the draft waiver implementation plan is made available to providers, recipients, the Indian Health Advisory Board, the Medical Care Advisory Committee and the public at large. The public is afforded the opportunity to provide feedback.</p>
<input type="checkbox"/>	<p>Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i></p>

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Appendix C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The State completed an initial analysis of services and the primary settings in which the services are delivered. The following determinations were made:

Settings Presumed to be Compliant:

Indirect Supports (No Setting)

Financial Management Services (3 Providers)

Financial Management Services are provided in support of self-directed or self-administered services (SAS). Services delivered through the SAS method enable the participant maximum flexibility in hiring staff of their choosing. Many Physical Disabilities Waiver services are provided through SAS.

Emergency Response Services (5 Providers)

Emergency Response Services are provided in the home to assure the participant's health and safety in a manner that promotes independence.

Specialized Medical Equipment Supplier (5 Providers)

Specialized Medical Equipment Supplies are provided in the home and community to assure the participant's health and safety in a manner that promotes independence.

Providers Requiring Additional Review:

No settings deemed as "requires additional review".

As part of its Statewide Transition Plan, the State intends to add requirements that all providers are responsible for ongoing monitoring of service settings to ensure compliance with Federal requirements. In addition, State quality assurance monitoring will also include the review of service settings.

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Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Person Centered Support Plan (PCSP)
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a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input checked="" type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input type="checkbox"/>	Case Manager (qualifications specified in Appendix C-1/C-3)
<input type="checkbox"/>	Case Manager (qualifications not specified in Appendix C-1/C-3). <i>Specify qualifications:</i>
<input type="checkbox"/>	Social Worker <i>Specify qualifications:</i>
<input checked="" type="checkbox"/>	Other <i>Specify the individuals and their qualifications:</i>
	Waiver recipient

b. Service Plan Development Safeguards.

Select one:

<input checked="" type="radio"/>	Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i>

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant’s authority to determine who is included in the process.

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Prior to the development of the PCSP, the administrative case manager may refer the individual to visit with their local Independent Living Center (ILC). The ILC will assist the participant to learn about available community resources.

The administrative case manager will provide training to the participants to ensure they are prepared to recruit, supervise and direct their own personal assistance services to fulfill the individualized PCSP.

The participant, administrative case manager and others at the invitation of the participant such as a representative to communicate participant decisions, family, friends and caregivers work together as a PCSP team. This PCSP team holds a planning meeting where the participant is directly involved in the development of their PCSP.

Participants, together with the PCSP team, identify personal goals and make decisions that are related to specific supports in their PCSP. The PCSP team can also assist the participant in making an informed choice when multiple service options are available. The participant has the authority to specify who participates in their person centered planning process.

- d. Service Plan Development Process** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant’s needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The PD Waiver administrative case manager, as part of the PCSP team, works in concert with the entire PCSP team to develop the PCSP.. The PCSP team meets together at scheduled times and locations convenient to both the waiver participant and other individuals whom the participant has invited to participate. As part of the process to develop the PCSP, the PCSP team identifies the waiver participant’s strengths, goals, preferences, needs, capacities and desired outcomes. The PCSP is developed and implemented in a manner that supports the waiver participant and recognizes him/her as central to the process. The administrative case manager also works with the PCSP team to enable and assist the participant to identify and access a unique mix of services to meet the participant’s assessed needs.

The PCSP is reviewed as frequently as necessary, with a formal review occurring at a minimum of annually (no later than by the end of the calendar month of the review, one year later). Annual individual budgets are developed with sufficient funds allocated to cover the array of services indicated in the PCSP. The PCSP and the budget are reviewed by the PCSP team and must be agreed upon by the participant and the administrative case manager. The PCSP and the budget are

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changed during the course of the year, as needed, to address participants' changing needs.

a) Who develops the plan, who participates in the process, and the timing of the plan;
The administrative case manager has ultimate responsibility to develop the PCSP; however, it is the entire PCSP team's responsibility to participate and develop the PCSP. The PCSP is reviewed and updated at least once a year with changes made throughout the year as needed based on the participant's needs. Anytime during the plan year the administrative case manager can choose to complete a whole new plan or make modifications (addendums) to the existing plan. The waiver participant or their representative may also request updates or changes to the existing plan outside of annual, formal reviews of the PCSP. Such requests would be addressed directly with the participant's administrative case manager.

(b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences, strengths, capacities, desired outcomes, risk factors, goals, and health status.

The PD Waiver utilizes a comprehensive approach to PCSP development. Important assessments include the Person Centered Profile, medical assessment, the MDS-HC and other therapy evaluations as needed and the review of the past year.

(c) How the participant is informed of the services that are available under the waiver.
Prior to the initial planning meeting with the PCSP team, the participant is given a list of all the services provided on the PD waiver including the definition of each service. In addition, the list of PD services is found on the DSPD website.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences.
The PCSP development process is based upon the participant's identified and expressed needs and strengths, as well as requirements for safe support in a community setting. The PCSP is created with the information gathered during the comprehensive assessment process using the MDS-HC to identify health care needs and based upon the contribution of the participant regarding their individual choices. The administrative case manager assists the participant to find out more information about individual providers. The waiver and non-waiver services are discussed with the PCSP team and based upon the participant's preferences; the frequency, duration and choice of provider are identified and included in the PCSP.

(e) How waiver and other services are coordinated.
The coordination of the PD Waiver and other services is a constant activity for the participant in services and the administrative case manager. Through quarterly face to face visits and monthly contacts with the participant, the administrative case manager is able to determine which services are being used successfully, what new services may be needed, if services are being duplicated and what services may need to be reviewed for effectiveness. The administrative case manager will document their activities in the Utah Systems for Tracking Eligibility, Planning and Services (USTEPS) log system.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan.
The PCSP contains information about specific PD Waiver services, including details on amount, duration, and frequency. It also identifies supports and services, who is providing the support, date the support will begin and end and details including provider requirements, such as, objectives, methods, procedures, data reporting, etc. The PCSP also includes information related to

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communication and coordination of services or supports with others. The payment source is also identified. For supports funded by the PD Waiver, the name of the contracted provider, the service code and the requirement for support strategies are documented.

(g) How and when the plan is updated, including when the participant’s needs change. The PCSP is reviewed and revised as frequently as necessary to address the participant’s changing needs. A formal review occurs at least annually and is completed during the calendar month in which it is due.

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The administrative case manager, during the comprehensive needs assessment process and PCSP development process will identify: Risks posed by the participant’s physical and environmental conditions and choice of services and supports to best meet the participant’s needs. In completing the risk analysis, specific emphasis will be placed on identifying risks that would result in a high likelihood of harm, death or institutionalization if an interruption in the delivery of services and supports to the waiver participant occurred.

The risk analysis will be reviewed with the waiver enrollee and others of the participant’s choosing. The PCSP will describe services and supports to be rendered to mitigate risks and will identify back-up plans for the provision of essential services.

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During the preparation of the written PCSP, the participant will be informed in writing by the administrative case manager of waiver service options available to address the identified needs and expectations of the participant. Provider options are made available for each selected waiver service.

The participant will be given a choice of all waiver services and waiver service providers. The participant selects the service(s) and provider(s) of their choice(s) and it is listed in their PCSP.

- g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The SMA retains final authority for oversight and approval of the person centered planning process. The oversight function involves reviews, occurring at a minimum of every two years, of a representative sample of waiver enrollees’ PCSPs that are sufficient to provide a confidence level equal to 95% and a confidence interval equal to five. A response distribution equal to 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review. If sample evaluations identify system-wide person centered planning problems, an expanded review is initiated by the SMA.

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- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

<input type="radio"/>	Every three months or more frequently when necessary
<input type="radio"/>	Every six months or more frequently when necessary
<input checked="" type="radio"/>	Every twelve months or more frequently when necessary
<input type="radio"/>	Other schedule <i>Specify the other schedule:</i>

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency
<input checked="" type="checkbox"/>	Operating agency
<input type="checkbox"/>	Case manager
<input type="checkbox"/>	Other <i>Specify:</i>

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Appendix D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

This waiver maintains a person centered focus. As such, the participant has a responsibility to identify areas of concern and report problems to his/her administrative case manager. In return, the administrative case manager is expected to provide a prompt response to all waiver participant inquiries as well as any reported concerns.

The entire PCSP team will also work with the participant to identify goals. However, administrative case managers specifically have the ultimate responsibility to employ a person centered approach during the goal identification process and will utilize that same approach to develop and complete the PCSP prior to implementation. At a minimum, the administrative case manager and participant shall have a face-to-face visit on a quarterly basis. One of the quarterly face to face visits will include the administration of the annual assessment of the MDS-HC for annual eligibility determination and person centered planning with the PCSP team. Additional contacts will take place on at least a monthly basis.

If any members of the PCSP team believe that the PCSP is not being implemented as outlined, including the participant, they should immediately contact the administrative case manager to resolve the issue by following the informal and, if necessary, the formal resolution process as identified in Appendix F.

Each month, the administrative case manager reviews the billing statement from the Financial Management Service (FMS) provider and the monthly budget sheet provided by DSPD's financial analyst. If these documents reveal over/under utilization, the administrative case manager contacts the participant to discuss the reasons why and then revises the budget if necessary.

Monitoring activities conducted by the administrative case manager also include the review of monthly provider summary notes, completion of the risk assessment, contingency plan development and the administration of annual satisfaction surveys.

DSPD is responsible for designing and implementing a quality management program. This program includes procedures for overseeing the performance of the needs assessment process, PCSP development and implementation process.

Additionally, DSPD is responsible to organize the content and timeframes of its quality assurance program. Program performance reviews are to be completed by DSPD staff that are not responsible for person centered planning and service delivery in order to objectively assess the accuracy and effectiveness of the link between the determination of need, the PCSP, the implementation of administrative case management services and the ongoing evaluation of progress towards the participant's stated goals.

All PCSPs are subject to annual and periodic post-payment review and approval by the SMA. At a minimum, formal monitoring of PCSPs is conducted at least every two years. The sample size for

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each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to five. During formal reviews, records are vigorously reviewed to verify that the PCSP addresses all of the participant's assessed needs, including health needs, safety risks and personal goals either by the provision of waiver services or other funding sources (State Plan services, generic services and natural supports). Significant findings from these reviews will be addressed with DSPD. A plan of correction with specific time frames for completion will be required. The SMA will conduct follow-up reviews as necessary to ensure the plan of correction is implemented and sustained.

b. Monitoring Safeguards. *Select one:*

<input checked="" type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
<input type="radio"/>	<p>Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.</p> <p>The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i></p>

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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Performance Measure: #1	Number and percentage of PCSPs that address all participants' assessed needs including health needs, safety risks and personal goals either by the provision of waiver services or other funding sources including State Plan, generic and natural supports. The numerator is the number of PCSPs in compliance; the denominator is the total number of PCSPs reviewed.		
Data Source	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
<ul style="list-style-type: none"> • Risk Assessment • PCSP • USTEPS 			
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: Every two years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years	

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Performance Measure: #2	Number and percentage of participants for whom there is sufficient documentation to ascertain whether participants have made progress on goals identified on the PCSP. Numerator = number of PCSPs reviewed that identify participant goals and for which there is sufficient documentation demonstrating progression of participants on those identified goals; Denominator = total number of PCSPs reviewed.		
Data Source <ul style="list-style-type: none"> • USTEPS • PCSP 	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: Every two years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years	

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- ii. **Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.**

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #1	Number and percentage of PCSPs reviewed and updated annually, completed during the calendar month in which it is due. The numerator is the number of reviewed PCSPs for which a review shows it was updated annually, completed during the calendar month in which it is due; the denominator is the total number of PCSPs reviewed.		
Data Source • USTEPS • PCSP	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: Every two years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

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	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years	

Performance Measure: #2	Number and percentage of PCSPs which are updated/revised when warranted by changes in the participant's needs. The numerator is the number of PCSPs which were updated/revised; the denominator is the total number of PCSPs which required updates/revision due to a change in need.		
Data Source	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
<ul style="list-style-type: none"> • USTEPS • PCSP 			
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: Every two years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years	

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iii. **Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #1	Number and percentage of PCSPs identifying the amount, frequency and duration for each service authorized. The numerator is the total number of PCSPs in the review which clearly identify the amount, frequency and duration for each waiver service authorized; the denominator is the total number of PCSPs reviewed.		
Data Source • PCSP	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: Every two years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that	Frequency of data aggregation and analysis: (check each that	

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	<i>applies</i>	<i>applies</i>	
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	
		<input checked="" type="checkbox"/> <i>Other: Specify: Every two years</i>	

iv. Sub-assurance: Participants are afforded choice: between/among waiver services/providers.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

<i>Performance Measure: #1</i>	Number and percentage of participants who are made aware of all services available on the PD Waiver. The numerator is the total number of participants reviewed who were made aware of all services available on the PD Waiver; the denominator is the total number of participants reviewed.		
<i>Data Source</i>	<i>Responsible Party for data collection/generation</i> (check each that applies)	<i>Frequency of data collection/generation:</i> (check each that applies)	<i>Sampling Approach</i> (check each that applies)
<ul style="list-style-type: none"> • USTEPS • PCSP 			
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error</i>
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i>

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		<input checked="" type="checkbox"/> Other: Specify: Every two years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years	

Performance Measure: #2	Number and percentage of participants who are offered choice among providers when more than one is available. The numerator is the total number of participants reviewed who are offered choice among providers when more than one is available; the denominator is the total number of participants reviewed.		
Data Source	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
<ul style="list-style-type: none"> • USTEPS • PCSP 			
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: Every two years.	
			<input type="checkbox"/> Other: Describe

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Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years.	

- v. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The PCSP team works together to develop the PCSP and must include, at a minimum, the participant and/or the participant’s representative and administrative case manager. All other individuals participating in the PCSP planning process attend at the invitation of the participant. The PCSP team must address health needs, safety risks and personal goals. Documentation in the participant’s record will contain adequate information to ascertain the progress that a participant has made on goals identified in the PCSP. Once an individual is enrolled in the waiver they are to receive the amount of covered services necessary to meet their health and safety needs and to prevent unnecessary institutionalization. If there have been significant changes, the assessment is updated. All services are identified on the PCSP regardless of funding source. Participants are offered choice of either nursing facility care or PD Waiver services and choice is documented on the PCSP. Participants are made aware of all services available on the PD Waiver and are offered choice among providers whenever choice exists.

b. Methods for Remediation/Fixing Individual Problems

- i. *Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

Individual issues identified by DSPD and the SMA that affect the health and welfare of

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individual participants are addressed immediately. Issues that are less immediate are corrected within designated time frames and are documented through the SMA Final Report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained by the SMA.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input checked="" type="checkbox"/> Other: Specify: Every two years

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

<input type="radio"/>	Yes (complete remainder of item)
<input checked="" type="radio"/>	No

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

<input checked="" type="checkbox"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input type="checkbox"/>	No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

<input type="checkbox"/>	Yes. The State requests that this waiver be considered for Independence Plus designation.
<input checked="" type="checkbox"/>	No. Independence Plus designation is not requested.

Appendix E-1: Overview

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver’s approach to participant direction.

Self-Administered Services (SAS) means service delivery that is provided through a non-agency based provider. Under this method, waiver participants are required to employ individual employees in order to receive personal assistance waiver services. The waiver participant is then responsible to perform the functions of hiring and supervising their employee, assuring that employee qualifications are met, scheduling the employee’s time, assuring accuracy of the time sheets, etc.

The SAS method necessitates the use of Financial Management Services (FMS), commonly known as a “Fiscal Agent”, to assist with managing employer-related financial responsibilities associated with SAS. These employer-related financial responsibilities include federal, state, and local tax withholding/payments, fiscal accounting, expenditure reports, Medicaid claims processing and reimbursement distribution. Administrative case managers are responsible to assist participants to successfully direct their personal attendance services.

The participant has budget authority as it pertains to their personal assistance staff. The participant decides how many employees they can afford to hire within the overall budgeted amount, the wages to be paid and the amount of hours worked. They are responsible to review all employee timesheets for accuracy and submit them to the FMS agent for payment. The FMS agent sends the employer information after each pay period detailing what was paid and the amount remaining in their budget.

Participants hire staff in accordance with Federal IRS and DOL rules and regulations (IRS Revenue Ruling 87-41; IRS Publication 15-A: Employer's Supplemental Tax Guide; FLSA Domestic Service Regulations in 29 CFR § 552.3).

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Once a participant's needs have been assessed and the PCSP and budget have been developed, the individual will be provided with a listing of the available FMS providers from which to choose. The individual will be referred to the FMS provider once a selection is made.

A copy of the participant's PCSP/approved budget worksheet will be given to the chosen provider of FMS. The worksheet will indicate the participant's total number of authorized funds. Allocated funds are only disbursed to pay for actual services rendered. All payments are made through FMS providers under contract with DSPD. Payments are not issued to the waiver participant, but to and in the name of the employee that was hired. The participant will be authorized for a rate to cover the costs of the employee wages and benefits reimbursement.

The administrative case manager monitors payments, reviews actual expenditures in comparison with the individual support plan and budget, contacts the waiver participant if any concerns arise and assists in resolution of billing problems.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

<input type="radio"/>	Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
<input checked="" type="radio"/>	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

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c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
<input type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements <i>Specify these living arrangements:</i>

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

<input checked="" type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input type="radio"/>	The waiver is designed to afford every participant (or the participant’s representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria</i>

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant’s representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

<p>During the eligibility and enrollment process, DSPD provides the participant with an orientation, which involves providing written materials as well as describing services available under the self-administered model. At that time it is further explained that by using the self-administered model, it is required that the participant use a qualified Financial Management Service agency to assist them with payroll functions. The responsibilities and potential liabilities of becoming an employer are also discussed.</p>	
---	--

f. Participant Direction by a Representative. Specify the State’s policy concerning the direction of waiver services by a representative (*select one*):

<input checked="" type="radio"/>	The State does not provide for the direction of waiver services by a representative.
<input type="radio"/>	The State provides for the direction of waiver services by representatives. <i>Specify the representatives who may direct waiver services: (check each that applies):</i>
<input type="checkbox"/>	Waiver services may be directed by a legal representative of the participant.
<input type="checkbox"/>	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. <i>Specify the policies that apply regarding the direction of waiver</i>

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		services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3. (*Check the opportunity or opportunities available for each service*):

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Personal Attendant Services	X	X
	<input type="checkbox"/>	<input type="checkbox"/>

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

X	Yes. Financial Management Services are furnished through a third party entity. (<i>Complete item E-1-i</i>). Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
<input type="checkbox"/>	Governmental entities
X	Private entities
○	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

X	FMS are covered as the waiver service specified in Appendix C-1/C-3 The waiver service entitled:	Financial Management Services
○	FMS are provided as an administrative activity. <i>Provide the following information</i>	
i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: The State uses private vendors to furnish FMS. Any qualified, willing provider may enroll to offer this service. The procurement method is the same as with all other services.	
ii.	Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:	

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	Not applicable. FMS is not an administrative function.
iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide (<i>check each that applies</i>):
	Supports furnished when the participant is the employer of direct support workers:
	X Assists participant in verifying support worker citizenship status
	X Collects and processes timesheets of support workers
	X Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
X Other <i>Specify:</i>	<p>Financial Management Services (FMS) will assist individuals in the following activities:</p> <ol style="list-style-type: none"> 1. Verify that the employee completed the following forms: <ol style="list-style-type: none"> a. Form I-9, including supporting documentation (i.e. copies of driver's license, social security card, passport). If fines are levied against the person for failure to report INS information, the Fiscal Agent shall be responsible for all such fines. b. Form W-4 2. Obtain a completed and signed Form 2678, Employer Appointment of Agent, from each person receiving services from the Financial Management Services provider, in accordance with IRS Revenue Procedure 70-6, 1970-1 C.B. 420. 3. Provide persons with a packet of all required forms when using an FMS provider, including all tax forms (IRS Forms I-9, W-4 and 2678), payroll schedule, FMS provider's contact information and training material for the web-based timesheet. 4. Process and pay Utah Department of Human Services/DSPD approved employee timesheets, including generating and issuing paychecks to employees hired by the participant. 5. Assume all fiscal responsibilities for withholding and depositing FICA and SUTA/FUTA payments on behalf of the person. Any federal and/or State penalties assessed for failure to withhold the correct amount and/or timely filing and depositing will be paid by the FMS provider. 6. Maintain a customer service system for persons and employees who may have billing questions or require assistance in using the web-based timesheet. The FMS provider will maintain an 800-number for calls received outside the immediate office area. Messages must be returned within 24 hours Monday thru Friday. Messages left between noon on Friday and Sunday evening shall be returned the following Monday.

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- a. Must have capabilities in providing assistance in English and Spanish. Fiscal Agent must also communicate through TTY, as needed, for persons with a variety of disabilities.
7. File consolidated payroll reports for multiple employers. The FMS provider must obtain federal designation as an FMS provider under Internal Revenue Services' (IRS) Rule in 26 CFR § 31.3504 (Acts to be Performed by Agents). An FMS provider must make an election with the appropriate IRS Service Center via Form 2678 (Employer Appointment of Agent). The FMS provider must carefully consider if they want to avail the Employers of the various tax relief provisions related to domestics and family employers. The FMS provider may forego such benefits to maintain standardization. Treatment on a case-by-case basis is tedious, and would require retroactive applications and amended employment returns. The FMS provider will, if required, comply with IRS Regulations in 26 CFR §§ 31.3306(a)(3)(c)(2), 31.3506, 31.3306(c)(5)-1 and 31.3506 (all parts), together with IRS Publication 926, Household Employer's Tax Guide. In order to be fully operational, the Form 2678 election should be postured to fall under two vintages yet fully relevant IRS Revenue Procedures: IRS Revenue Procedure 70-6, 1970-1 C.B. 420 allows the FMS provider to file one employment tax return, regardless of the number of employers they are acting for, provided the FMS provider has a properly executed Form 2678 from each Employer; and IRS Revenue Procedure 80-4, 1980-1 C.B. 581 amplifies IRS Revenue Procedure 70-6, 1970-1 C.B. 420, and does away with the multiple Form 2678 requirements, by imposing more stringent record keeping requirements on the FMS provider.
8. Obtain IRS approval for Agent status. The FMS provider shall consolidate the federal filing requirements, obtain approval for Utah State Tax Commission consolidated filings, and obtain approval for consolidated filing for unemployment insurance through the Department of Workforce Services. For those Employers retaining domestic help less than 40 hours per week, Workers Compensation coverage is optional. If the 40-hour threshold is achieved or exceeded, the Worker's Compensation Act requires coverage. Statutory requirements and the nature of insurance entail policies on an individual basis. Consolidated filings of Workers Compensation are not an option.
9. The FMS provider cannot provide waiver recipients with community-based services in addition to FMS.

Supports furnished when the participant exercises budget authority:

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Maintains a separate account for each participant's participant-directed budget |
| <input type="checkbox"/> | Tracks and reports participant funds, disbursements and the balance—of participant funds |
| <input type="checkbox"/> | Processes and pays invoices for goods and services approved in the service plan |
| <input type="checkbox"/> | Provide participant with periodic reports of expenditures and the status of the participant-directed budget |
| <input type="checkbox"/> | Other services and supports |
| | <i>Specify:</i> |
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	<p>Additional functions/activities:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">X</td> <td>Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency</td> </tr> <tr> <td style="text-align: center;">X</td> <td>Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency</td> </tr> <tr> <td style="text-align: center;">X</td> <td>Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>Other <i>Specify:</i></td> </tr> <tr> <td colspan="2" style="height: 20px;"></td> </tr> </table>	X	Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency	X	Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency	X	Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget	<input type="checkbox"/>	Other <i>Specify:</i>		
X	Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency										
X	Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency										
X	Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget										
<input type="checkbox"/>	Other <i>Specify:</i>										
iv.	<p>Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.</p> <p>Service providers, administrative case managers and others, who assist in the development and delivery of supports for people served through DSPD, will be expected to maintain established standards of quality. The SMA and DSPD will assure that high standards are maintained by way of a comprehensive system of quality assurance including: (a) formal surveys of providers for measurement of individual and organizational outcomes, (b) contract compliance reviews, (c) regular observation and evaluation by administrative case managers, (d) provider quality assurance systems, (e) participant/family satisfaction measures, (f) performance contracts with and reviews of State agency staff, (g) audits completed by entities external to the agency and (h) other oversight activities as appropriate.</p> <p>DSPD improved the accountability of SAS service delivery through standardized mandatory training and manuals for SAS families and administrative case managers and a formal documentation monitoring tool used by administrative case managers to audit SAS employers.</p>										

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j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

<input type="checkbox"/>	<p>Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.</p> <p><i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i></p>				
<input checked="" type="checkbox"/>	<p>Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-1/C-3 (check each that applies):</p> <table border="1"> <thead> <tr> <th align="center">Participant-Directed Waiver Service</th> <th align="center">Information and Assistance Provided through this Waiver Service Coverage</th> </tr> </thead> <tbody> <tr> <td align="center">Financial Management Services</td> <td align="center">X</td> </tr> </tbody> </table>	Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage	Financial Management Services	X
Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage				
Financial Management Services	X				
<input checked="" type="checkbox"/>	<p>Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.</p> <p><i>Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and (e) the entity or entities responsible for assessing performance:</i></p> <p>The administrative case manager, as an employee of DSPD, is responsible to oversee and/or perform the following essential activities directly connected to ensuring the proper and efficient operation of the PD Waiver:</p> <ul style="list-style-type: none"> • Forward necessary documentation to support timely medical and Medicaid eligibility determination for waiver applicants and participants to Medicaid's Eligibility Services and the Bureau of Authorization and Community Based Services, respectively; • Oversee and actively participate in the person centered planning process and periodically monitor the delivery of services; • Determine a participant's overall need for waiver services, as well as assess the need for supplemental evaluation in cases where the participant's needs are skilled in nature and are outside the ability of the waiver provider's licensed/certified ability (if required); • Assist participants to identify waiver service providers, community based resources, natural supports and to make informed choices when there are multiple provider options available to offer services identified in the PCSP; • Assist participants to obtain and maintain needed Medicaid (state plan and waiver) benefits; • Instruct participants in methods of identifying need and effectively communicating those needs to service providers; • Instruct participants in management of personal attendant(s) including interviewing, selecting, scheduling, termination, time sheeting, evaluating performance and back up coverage; • Instruct participants in addressing problems such as changing levels of personal needs, grievance procedures, emergency coverage, exploitation and abuse; • Regularly evaluate the effectiveness of the waiver through the performance of quarterly face to face visits with the participant; 				

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- During quarterly face to face visits, ensure immediate participant notification in the event of substantial changes in the participant’s health, safety, local waiver program environment or requests for changes in participant services;
- Provide/arrange as appropriate, the delivery of SAS method training and instruction to the participant;
- Assist qualified individuals to enroll as providers of waiver services;
- Conduct outreach activities to identify and inform potential participants, their families and other interested parties, in the community, about the waiver program;
- Ensure applicant/participant rights including rights to fair hearing;

- Coordinate waiver services with enrolled Medicaid Nursing Facilities to assure a participant’s smooth transition between nursing facilities and community-based settings;
- Participate in joint program reviews with the SMA;
- Compile information, data and reports to support the above functions and as required by the SMA and CMS;
- Other duties as jointly agreed to by the SMA and DSPD as covered in the interagency agreement.

QUALIFICATIONS

- Must be licensed in the State of Utah as a Registered Nurse in accordance with Utah Code Annotated (UCA) § 58; and an employee of DSPD.

k. Independent Advocacy (*select one*).

<input checked="" type="radio"/>	No. Arrangements have not been made for independent advocacy.
<input type="radio"/>	Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i>

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

<p>The PD Waiver supports only those individuals who are willing and capable to self-direct their own services. If a participant voluntarily chooses not to self-direct their services, the process of transitioning the person out of the PD Waiver will begin. During the transition period, coordination of necessary health and welfare supports is provided through the waiver until the person is enrolled in another program that will meet their needs.</p> <p>The Division of Medicaid and Health Financing (DMHF), in partnership with DSPD, will compile information on voluntary disenrollments.</p>
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m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-

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managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The PD Waiver supports only those individuals who are willing and capable of self-directing their own services. If a participant is assessed to be unable to self-direct their services, the process of transitioning the person out of the PD Waiver will begin. During the transition period, coordination of necessary health and welfare supports is provided through the waiver until the person is enrolled in another program that will meet their needs.

Special circumstance disenrollments, as described in the PD Waiver Provider manual and which require SMA approval, entail such cases that are non-routine in nature and involve circumstances that are specific to the participant involved.

- n. Goals for Participant Direction.** In the following table, provide the State’s goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		140
Year 2		140
Year 3		140
Year 4 (only appears if applicable based on Item 1-C)		140
Year 5 (only appears if applicable based on Item 1-C)		140

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Appendix E-2: Opportunities for Participant-Direction

a. **Participant – Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. **Participant Employer Status.** Specify the participant’s employer status under the waiver. *Select one or both:*

<input type="checkbox"/>	<p>Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.</p> <p>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:</p>
<input checked="" type="checkbox"/>	<p>Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.</p>

ii. **Participant Decision Making Authority.** The participant (or the participant’s representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

<input checked="" type="checkbox"/>	Recruit staff
<input checked="" type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
<input checked="" type="checkbox"/>	Hire staff (common law employer)
<input checked="" type="checkbox"/>	Verify staff qualifications
<input checked="" type="checkbox"/>	<p>Obtain criminal history and/or background investigation of staff Specify how the costs of such investigations are compensated: DSPD is responsible to pay any fees associated with background investigations.</p>
<input checked="" type="checkbox"/>	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.
<input checked="" type="checkbox"/>	Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
<input checked="" type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits
<input checked="" type="checkbox"/>	Schedule staff
<input checked="" type="checkbox"/>	Orient and instruct-staff in duties
<input checked="" type="checkbox"/>	Supervise staff
<input checked="" type="checkbox"/>	Evaluate staff performance
<input checked="" type="checkbox"/>	Verify time worked by staff and approve time sheets
<input checked="" type="checkbox"/>	Discharge staff (common law employer)

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<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other Specify:

b. Participant – Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

<input type="checkbox"/>	Reallocate funds among services included in the budget
X	Determine the amount paid for services within the State’s established limits
X	Substitute service providers
X	Schedule the provision of services
X	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
X	Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
X	Identify service providers and refer for provider enrollment
<input type="checkbox"/>	Authorize payment for waiver goods and services
X	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other Specify:

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Utilizing the score derived from the Personal Assistance Critical Needs Assessment and the assessment information from the MDS-HC, the administrative case manager estimates the participant’s prospective budget amount. During the annual person centered planning process, the participant’s needs and available services are discussed with the participant. An individualized waiver services budget is agreed upon. The participant, in collaboration with the administrative case manager, decides how the funds should be allocated among the waiver services to assure the health and safety of the participant.

The process employed for determining participant-directed budgets is open to public inspection during the development of the state implementation plan. At a minimum, the draft waiver implementation plan is made available to providers, participants, the Indian Health Advisory Board, the Medical Care Advisory Committee and the public at large. The public is afforded the opportunity to provide feedback.

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- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Once the draft plan is drawn up, the administrative case manager communicates the amount budgeted for each type of service included in the plan.

Each month the participant receives a report from the FMS Fiscal Agent that provides information on the budgeted amount utilized and the funds remaining. The participant can also contact the administrative case manager at any time to find out the current balance of the budget. The administrative case manager reviews what has been spent each month and monitors whether the plan needs any adjustments due to crisis, loss of caregiver or other deterioration in participant functioning.

If at any time the participant's service needs change or a health and safety issue arises, the participant is responsible to contact their administrative case manager with these changes. If the participant requests an increase in their services, they may petition in writing for additional funds. The administrative case manager will complete a new MDS-HC, Critical Needs Assessment and review the present PCSP. These documents are presented to the PD Waiver Program Manager for review.

If additional funding is approved, the administrative case manager notifies the participant, changes are made to the participant's PCSP and funding allocation plan. If the request is denied, the participant receives a Notice of Agency Action and information relating to their hearing rights.

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

<input checked="" type="checkbox"/>	Modifications to the participant directed budget must be preceded by a change in the service plan.
<input type="checkbox"/>	<p>The participant has the authority to modify the services included in the participant directed budget without prior approval.</p> <p>Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:</p>

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Each month the administrative case manager reviews the billing statement from the Financial Management Services provider and a monthly budget sheet from DSPD's financial analyst. If these documents reveal over/under utilization, the administrative case manager contacts the participant to discuss the reasons why and will revise the budget if necessary.

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Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

RIGHTS TO A FAIR HEARING DOCUMENTATION

1. DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

An individual, and their representative (if applicable), will receive a written Notice of Agency Action, Form 522 and a Hearing Request Form 490S from a DSPD administrative case manager if the individual is denied a choice of institutional or waiver program, found ineligible for the waiver program denied access to the provider of choice for a covered waiver service or experiences a denial, reduction, suspension or termination of waiver services in accordance with R539-2-5. In instances in which an individual is found to be ineligible for entrance to the waiver, they may request an administrative fair hearing from the Department of Human Services, which is dispositive. The person may request assistance from the Disability Law Center, Utah's statutory protection and advocacy organization, or other rights and advocacy organizations in arranging for and participating in this hearing. Services are not afforded during this period of pendency.

The Notice of Agency Action delineates the individual's right to appeal the decision through an informal hearing process at the Department of Human Services or an administrative hearing process at the Department of Health, or both. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions.

Appeals exclusively related to establishing eligibility for state matching funds through DSPD/Utah Department of Human Services in accordance with UCA 62A-5 will be addressed through the Department of Human Services hearing process. Decisions made through the Department of Human Services hearing process on the question of DSPD eligibility may be appealed to the Department of Health strictly for procedural review. Appealed decisions, which demonstrate that the Department of Human Services followed the fair hearing process, will be upheld by the Department of Health as the final decision.

Notices and the opportunity to request a fair hearing documentation are kept in the individual's case record with DSPD. All waiver participants must acknowledge having been advised of the fair hearing process upon enrollment and annually thereafter as documented in the Person Centered Support Plan or PCSP.

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Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

<input type="radio"/>	No. This Appendix does not apply
<input checked="" type="radio"/>	Yes. The State operates an additional dispute resolution process

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Department of Human Services has an informal hearings process and DSPD has an informal dispute resolution process. The informal dispute resolution process is designed to respond to a participant’s concerns without unnecessary formality. The dispute resolution process is not intended to limit a participant’s access to formal hearing procedures; the participant may file a Request for Hearing any time in the first 30 days after receiving Notice of Agency Action. Examples of the types of disputes include but are not limited to: concerns with a provider of waiver services, concerns with the amount, frequency or duration of services being delivered, concerns with provider personnel, etc.

When DSPD receives a Hearing Request Form (490S), a two-step resolution process begins with:

1. The Division staff explain the regulations on which the action is based and attempt to resolve the disagreement; and then,
2. If a resolution is not reached, DSPD staff arrange a review meeting between the participant and the DSPD Director (Director) or the Director's designee.

Attempts to resolve disputes are completed as expeditiously as possible. No specific time frame has been set due to the fact that some issues may be resolved very rapidly while other, more complex issues may take a greater period of time to resolve.

If the resolution process is not able to resolve the problem, the participant may request an informal hearing with a hearing officer within the Department of Human Services Office of Administrative Hearings.

This informal hearing reviews the information DSPD used to make a decision or take an action as well as review of information from the participant and/or their legal representative, if applicable, demonstrating why the decision or action is not correct.

DSPD Policy 1.11 Conflict Resolution requires the administrative case manager to provide information to waiver participants on the conflict resolution process and on how to contact DSPD. DSPD reviews all complaints submitted either orally or in written form and any relevant information submitted with the complaint. DSPD will take appropriate action to resolve the dispute and respond to all parties concerned. If the parties are unable to resolve the dispute, either party may appeal to the Director or designee.

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The Director or designee will meet with the parties and review any evidence presented. The Director or designee shall determine the best solution for the dispute. The Director or designee will prepare a concise written summary of the finding and decision and send it to the parties involved. Either party may request an independent review if they do not agree with the Director's decision. Based on interviews with the parties and a review of the evidence, the independent reviewer will prepare, for the Director, a written summary of the factual findings and recommendations. Based on the independent reviewer's report, the Director will determine the appropriate resolution for the dispute and shall implement any necessary corrective action.

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Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

<input type="radio"/>	No. This Appendix does not apply
<input checked="" type="radio"/>	Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Utah Department of Human Services, Division of Services for People with Disabilities, and the Utah Department of Health, Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

PD Waiver participants may file a written or verbal complaint/grievance with the Utah Department of Human Services /Division of Services for People with Disabilities Constituent Services Representative (Representative). There is no limit to the amount of elapsed time that has occurred when a complaint may be filed. This Representative is specifically assigned to DSPD, although operates independent of them. When the Representative receives a complaint there is an investigation involving all pertinent parties. The Representative then works with the parties to come to a resolution.

Both the Department of Human Services and the Utah Department of Health have constituent services available. Participants may call and verbally register a complaint/grievance. The respective constituent services representative ensures the caller is referred to the appropriate party for problem resolution.

The types of complaints that can be addressed through the grievance/complaint system include but are not limited to: Complaints about a provider of waiver services, complaints about the way in which providers deliver services, complaints about individual personnel within a provider agency, complaints about DSPD and its administrative program managers and other personnel associated with DSPD or decisions made or actions taken by those personnel, etc.

The Quality Assurance Team within the Bureau of Authorization and Community Based Services investigates complaints/grievances that are reported to the SMA and pertain to the operation of the PD Waiver. The SMA makes all efforts to resolve the complaint/grievance to the satisfaction of all parties within two weeks of the submission of the complaint/grievance. Some complaints/grievances may require additional time to investigate and implement a resolution. Findings and resolutions of all complaints/grievances are documented by fiscal year in the SMA complaint/grievance data base.

Participants are informed that filing a complaint is not a prerequisite or a substitute for a hearing.

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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

<input checked="" type="radio"/>	Yes. The State operates a Critical Event or Incident Reporting and Management Process <i>(complete Items b through e)</i>
<input type="radio"/>	No. This Appendix does not apply <i>(do not complete Items b through e).</i> <i>If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.</i>

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

<p>State Medicaid Agency (SMA) Critical Event or Incident Reporting Requirements:</p> <p>There are three levels of critical incidents/events. DSPD is required to report Level I Critical Incidents/Events to the SMA within 24 hours or on the first business day after the incident/event occurs to or by a participant.</p> <p>Level I Critical Incidents/Events include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Abuse/Neglect (either alleged or substantiated) that result in the participant’s admission to the hospital. 2. Suicide Attempts that resulted in the participant’s admission to the hospital. 3. Human Rights Violations such as the unauthorized use of restraints (physical, mechanical or chemical), seclusion rooms or infringements of participant’s privacy rights experienced by the participant. 4. Incidents Involving the Media or Referred by Elected Officials. 5. Medication Errors that resulted in the participant’s admission to the hospital. 6. Missing participant that has been missing for at least 24 hours; or regardless of the number of hours missing-participant who is missing under unexplained, involuntary or suspicious circumstances and is believed to be in danger because of age, health, mental or physical disability, environment or weather or who could be in the company of a potentially dangerous person or some other factor that places the participant in peril. 7. Unexpected Deaths-all deaths are unexpected except, participants receiving hospice care; and/or deaths due to natural causes, general system failure or terminal/chronic health conditions.
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8. Unexpected Hospitalizations due to serious burns, self-injurious behaviors or injuries resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a participant that resulted in admission to the hospital for medical treatment.
9. Waste and Fraud or Abuse of Medicaid Funds-incidents that involved alleged or confirmed waste, fraud or abuse of Medicaid funds by either a provider or a recipient of Medicaid services.

Operating Agency (DSPD) Critical Event or Incident Reporting Requirements:

DSPD requires the administrative case manager to report Level II Critical Incidents/Events to DSPD within 24 hours or on the first business day after the incident occurs either to or by the participant.

Level II Critical Incidents/Events include, but are not limited to:

1. Abuse/Neglect (either alleged or substantiated) that result in medical treatment at a medical clinic or emergency room or exploitation of the participant's funds.
2. Attempted Suicides that did not result in the participant being admitted to a hospital.
3. Compromised Working or Living Environment in which the participant's working or living environment is compromised and the participant requires evacuation.
4. Law Enforcement Involvement –activities perpetrated by the participant resulting in charges filed by law enforcement.
5. Medication Errors which resulted in the participant experiencing adverse side effects requiring medical treatment at a medical clinic or emergency room.
6. Unexpected Hospitalization due to injuries and aspiration or choking experienced by the participants that resulted in admission to a hospital.

DSPD also requires the administrative case manager to submit Level III Incidents/Events to DSPD within 24 hours or on the first business day after the incident occurs either to or by a participant.

Level III Incidents/Events include, but are not limited to:

1. Abuse/Neglect/Maltreatment (alleged or substantiated) where medical treatment was not required.
2. Suicide Threats when the participant does not have services and supports in place to address it or is not already receiving treatment.
3. Law Enforcement Involvement, where no charges are filed against the participant.
4. Medication Errors relating to the participant's medication, which resulted in the participant experiencing adverse side effects, but did not require medical treatment at a medical clinic or emergency room.
5. Hospitalizations due to medical or psychiatric reasons.
6. Institutional Admittance(s) as accommodation in a nursing home or a hospital.
7. Injuries requiring medical treatment at a medical clinic or emergency room.
8. Self-injurious Behaviors requiring medical treatment.
9. Aspiration or Choking which did not result in hospitalization.
10. Evidence of Seizure or Seizure Like Behavior in a participant with no existing seizure diagnosis.
11. Drug or Alcohol Abuse.
12. Missing participant for at least two hours.
13. Instances of any Property Destruction attributed to the participant (\$500 or more).

The administrative case manager is also responsible for following the mandatory reporting requirements of Utah Code Annotated (UCA) § 62-A-3-301 through 321 for adults which always

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take precedence. Therefore, in the case of actual or suspected incidents of abuse, neglect, exploitation, or maltreatment of an adult, the administrative case manager shall immediately notify Adult Protective Services intake or the nearest law enforcement agency. Administrative case managers must notify DSPD of an incident/event within the time frame noted above, by filling out the incident notification in the USTEPS/UIP system.

Within five (5) business days, the administrative case manager is responsible to complete the incident report in the USTEPS/UIP system.

After the incident report has been submitted in the USTEPS/UIP system, the administrative case manager will have five (5) business days to review the information in the incident report. He/she will complete the "Support Coordinator Follow-Up" section of the incident report and will develop prevention strategies, when appropriate, and will conduct a face-to-face visit with the participant, when appropriate, to ensure the prevention strategies were implemented or other safeguards were put in place to address the situation that had occurred.

If DSPD feels an incident report may be a Level I Critical Incident/Event, they forward the incident report to SMA for review. If the SMA feels it meets the criteria of a Level I Critical Incident/Event they will inform DSPD that they are accepting it for investigation. DSPD will classify the incident report in the USTEPS/UIP system as a Level I Critical Incident, which will notify the administrative case manager that they need to complete the investigation in the USTEPS/UIP system within ten (10) business days of it being classified as a Level I Critical Incident/Event. When the investigation is completed, DSPD will review the investigation and forward it to SMA.

If DSPD feels that an incident report meets the criteria of a Level II Critical Incident/Event, they will classify the incident report in the USTEPS/UIP system as a Level II Critical Incident, which will notify the administrative case manager that they need to complete the investigation in the USTEPS/UIP system within ten (10) business days of it being classified as a Level II Critical Incident/Event.

Follow-up questions may be asked, by the SMA or DSPD, on an incident report/event and/or on a critical incident/event investigation. The administrative case manager will have five (5) business days to respond to their questions in the USTEPS/UIP system. Additional questions may be asked or other documents may be requested.

When the SMA and DSPD determine the investigation is completed, they will fill out the SMA/Operating portion of the investigation form which will reflect a summary of the incident/event, remediation activities, findings and recommendations.

Within two weeks after closing the investigation, the SMA or DSPD will notify the participant of the investigation results.

The death of a waiver participant is subject to a full review of the circumstances surrounding the death by the DSPD Fatality Review Coordinator for the most recent year of services. The DSPD Fatality Review Coordinator will then compile a report that is reviewed by the full Fatality Review Committee.

Incident reports are compiled in the USTEPS/UIP system and are analyzed for trends. The information is utilized by DSPD to identify potential areas for quality improvement.

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DSPD submits quarterly waiver reports to the SMA for each waiver DSPD administers. The quarterly waiver reports summarize the Level II Critical Incidents/Events Investigations which DSPD has investigated and documents their findings or corrective action requirements. DSPD also submits an annual report to the SMA as well.

The SMA reviews all of the waiver reports for each waiver that reflects the Level II Critical Incident/Events that DSPD has investigated to assure interventions are taken to protect the health and safety of the participant being served. The SMA reviews the waiver reports to determine if the incident could have been avoided, if additional supports or interventions have been implemented to prevent the incident from recurring, if changes to the participant's Person Centered Support Plan and/or the participant's budget have been made and if any systemic issues were identified, and if so, was a plan to address the systemic issues developed.

In the event the SMA determines that a system issue has not been adequately addressed, DSPD will submit a plan of correction to the SMA. All plans of correction are subject to acceptance by the SMA. The SMA will conduct follow-up activities to determine that system corrections have been achieved and are sustaining.

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The administrative case manager provides the participant with information/training on the following topics: (a) how to avoid theft/security issues; (b) maintaining personal safety when recruiting/interviewing potential employees; (c) assertiveness/boundaries/rules with employees; (d) maintaining personal safety when firing an employee; (e) when and how to contact and report instances of abuse, neglect, exploitation; (f) resources on a local level to assist the participant if they are a victim of abuse, neglect or exploitation; and (g) fraud awareness and prevention.

Participant training and education is provided upon enrollment in the waiver and as needed thereafter.

- d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Responsibility of the SMA

The SMA has the responsibility for reviewing all of the critical incidents/events that are reported through the USTEPS/UPI system for the State of Utah. They investigate Level I Critical Incidents/Events to assure interventions are taken to protect the health and safety of the participants being served.

The SMA has the responsibility of investigating the Level I Critical Incidents/Events after DSPD forwards the critical incidents/events to them. When they determine that the investigation is

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completed, they will document their findings or corrective action requirements on the SMA portion of the investigation form and forward the investigation document to DSPD for review.

If the SMA determines that corrective action is needed, DSPD will respond to their findings. The SMA also has the responsibility of following the mandatory reporting requirements of UCA § 62-A-3-301 through 321 for adults which always take precedence. Therefore, in the case of actual or suspected incidents of abuse, neglect, exploitation or maltreatment of an adult, the administrative case manager shall immediately notify Adult Protective Services intake or the nearest law enforcement agency.

The SMA reviews all of the waiver reports for each waiver that reflects the Level II Critical Incident/Events that DSPD has investigated to assure interventions are taken to protect the health and safety of the participants being served. The SMA reviews the waiver reports to determine if the incident could have been avoided, if additional supports or interventions have been implemented to prevent the incident from recurring, if changes to the participant's Person Centered Support Plan and/or the participant's budget have been made and if any systemic issues were identified, and if so, was a plan to address the systemic issues developed.

Responsibility of the Operating Agency

DSPD has the responsibility for receiving and reviewing all of the incidents/events that are entered through the USTEPS/UIP system for the State of Utah. They will refer Level I Critical Incidents/Events to the SMA to investigate and will investigate Level II Critical Incidents/Events to assure interventions are taken to protect the health and safety of the participants being served.

DSPD will forward incident reports that may be Level I Critical Incidents/Events to the SMA for review. If they accept the incident/event for investigation they will classify the incident report as a Level I Critical Incident/Event, so the administrative case manager can be notified that they need to fill out the investigation in the USTEPS/UIP system within ten (10) business days.

If the SMA has follow-up questions that they would like to ask, DSPD has the responsibility of forwarding their questions to the administrative case manager. The administrative case manager will have five (5) business days to respond to their questions. Once their response is received, DSPD forwards the response to the SMA. Additional questions may be asked or other documents may be requested.

When the SMA has completed the investigation, they will fill out the SMA/Operating portion of the investigation form. It will reflect a summary of the incident/event, remediation activities, findings and recommendations. If the SMA determines that corrective action is needed, DSPD shall forward their recommendations to the administrative case manager so their recommendations can be addressed. Once it's been addressed, the administrative case manager will notify DSPD of that and they in turn will notify the SMA.

Within two weeks of closing the investigation, the SMA will notify the participant of the results of the investigation.

If an incident report meets the criteria of a Level II Critical Incident/Event, DSPD will classify the incident report as a Level II Critical Incident/Event so the administrative case manager can be notified that they need to fill out the investigation in the USTEPS/UIP system within ten (10) business days.

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DSPD will ask the administrative case manager follow-up questions. The administrative case manager will then have five (5) business days to respond to those questions in the USTEPS/UIP system. Additional questions may be asked or other documents may be requested.

When DSPD has completed the investigation, they will fill out the SMA/Operating portion of the investigation form. This will reflect a summary of the incident/event, remediation activities, findings and recommendations. If DSPD determines that corrective action is needed, DSPD shall forward their recommendations to the administrative case manager so their recommendations can be addressed. Once it's been addressed, the administrative case manager will notify DSPD.

Within two week of closing the investigation, DSPD will notify the participant of the results of the investigation.

DSPD also has the responsibility of following the mandatory reporting requirements of UCA § 62-A-3-301 through 321 for adults which always take precedence. Therefore, in the case of actual or suspected incidents of abuse, neglect, exploitation or maltreatment of an adult, the administrative case manager shall immediately notify Adult Protective Services intake or the nearest law enforcement agency. DSPD will also fill out the waiver report for each wavier and submit that to the SMA to review quarterly. DSPD will also submit an annual report as well.

In the event the SMA determines that a system issue has not been adequately addressed, DSPD will submit a plan of correction to the SMA. All plans of correction are subject to acceptance by the SMA. The SMA will conduct follow-up activities to determine that systems corrections have been achieved and are sustaining.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Oversight Responsibility of Critical Incidents/Events of the SMA:

The SMA reviews 100% of critical incident events that were submitted through the USTEPS/UIP system annually. The SMA also reviews the DSPD quarterly waiver reports and their annual report. If the SMA detects systemic problems either through this reporting mechanism or during the SMA's program review process, DSPD will be requested to submit a plan of correction to the SMA. The plan of correction will include the interventions to be taken and the time frame for completion. All plans of correction are subject to acceptance by the SMA. The SMA will conduct follow-up activities to determine that systems corrections have been achieved and are sustaining.

Oversight Responsibility of Critical Incidents/Events of the Operating Agency:

DSPD has the responsibility to review all critical incidents/events. DSPD will then forward the Level I Critical Incidents/Events to the SMA to investigate and investigate all of the Level II Critical Incidents/Events.

Incident reports are entered into the USTEPS/UIP system and are analyzed for trends. The information is utilized to identify prevention strategies on a system wide basis and identify potential areas for quality improvement.

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Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints (select one): *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

<input checked="" type="checkbox"/>	<p>The State does not permit or prohibits the use of restraints</p> <p>Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:</p> <hr/> <p>The SMA has established a Critical Incident/Event notification system as described in Appendix G-1(b) that requires DSPD to notify the SMA of any serious incidents including the use of restraints that are reported as part of critical incident notifications.</p> <p>DSPD also verifies that there is no use of restraints when conducting on site visits and performing annual reviews. Any incidents involving the use of restraints would be immediately reported to Adult Protective Services.</p> <p>Administrative case managers have the day to day responsibility to assure that there are no incidents involving the use of restraints.</p>
<input type="checkbox"/>	<p>The use of restraints is permitted during the course of the delivery of waiver services.</p> <p>Complete Items G-2-a-i and G-2-a-ii:</p>

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

b. Use of Restrictive Interventions

<input checked="" type="checkbox"/>	<p>The State does not permit or prohibits the use of restrictive interventions</p> <p>Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:</p> <hr/> <p>The SMA has established a Critical Incident/Event notification system as described in Appendix G-1(b) that requires DSPD to notify the SMA of any serious incidents including the use of restrictive interventions that are reported as part of critical incident notifications.</p>
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	<p>DSPD also verifies that there is no use of restrictive interventions when conducting on site visits and performing annual reviews. Any incidents involving the use of restrictive interventions would be immediately reported to Adult Protective Services.</p> <p>Administrative case managers have the day to day responsibility to assure that there are no incidents involving the use of restrictive interventions.</p>
<input type="radio"/>	<p>The use of restrictive interventions is permitted during the course of the delivery of waiver services. Complete Items G-2-b-i and G-2-b-ii.</p>

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- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

<input checked="" type="radio"/>	<p>The State does not permit or prohibits the use of seclusion</p> <p>Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:</p> <p>The SMA has established a Critical Incident/Event notification system that requires DSPD to notify the SMA of any serious incidents including the use of seclusion reported as part of critical incident notifications.</p> <p>DSPD also verifies that there is no use of seclusion when conducting on site visits and performing annual reviews. Any incidents involving the use of seclusion would be immediately reported to Adult Protective Services.</p> <p>Administrative case managers have the day to day responsibility to assure that there are no incidents involving the use of seclusion.</p>
<input type="radio"/>	<p>The use of seclusion is permitted during the course of the delivery of waiver services.</p> <p>Complete Items G-2-c-i and G-2-c-ii.</p>

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

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Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

<input checked="" type="radio"/>	No. This Appendix is not applicable <i>(do not complete the remaining items)</i>
<input type="radio"/>	Yes. This Appendix applies <i>(complete the remaining items)</i>

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and (c) the State agency (or agencies) that is responsible for follow-up and oversight.

c. Medication Administration by Waiver Providers

- i. Provider Administration of Medications.** *Select one:*

<input type="radio"/>	Not applicable <i>(do not complete the remaining items)</i>
<input type="radio"/>	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. <i>(complete the remaining items)</i>

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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iii. Medication Error Reporting. *Select one of the following:*

<input type="radio"/>	<p>Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i></p> <p>(a) Specify State agency (or agencies) to which errors are reported:</p> <p>_____</p> <p>(b) Specify the types of medication errors that providers are required to <i>record</i>:</p> <p>_____</p> <p>(c) Specify the types of medication errors that providers must <i>report</i> to the State:</p> <p>_____</p>
<input type="radio"/>	<p>Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.</p> <p>Specify the types of medication errors that providers are required to record:</p> <p>_____</p>

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

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Quality Improvement: Health and Welfare

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

- i. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.*

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

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For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #1	Number and percentage of suspected abuse, neglect and exploitation incidents referred to Adult Protective Services and/or law enforcement as required by State law. The numerator is the total number of incidents reported correctly; the denominator is the total number of reported incidents reviewed involving suspected abuse, neglect and/or exploitation.		
Data Source USTEPS Incident Reports DSPD Annual Incident Report	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years	

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Performance Measure: #2	Number and percentage of incidents involving abuse, neglect and exploitation of waiver participants where recommended actions to protect health and welfare were implemented. The numerator is the total number of reported incidents where recommended actions to protect health and welfare were implemented; the denominator is the total number of incidents requiring safeguards.		
Data Source Incident Reports	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years	

Performance	Number and percentage of waiver participant deaths for which the
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Measure: #3	Department of Human Services' Fatality Review Committee process was followed. The numerator is the total number of waiver participant deaths for which the Department of Human Services' Fatality Review Committee process was followed; the denominator is the total number of waiver participant deaths.		
Data Source USTEPS	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

ii. **Sub-assurance: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.**

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

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For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #1	Number and percentage of incidents reported to the Division of Services for People with Disabilities within 24 hours of the discovery of the occurrence. The numerator is the total number of incidents reviewed that were reported to the Division of Services for People with Disabilities within 24 hours of the discovery of the occurrence; the denominator is the total number of incidents reviewed.		
Data Source USTEPS Incident reports	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	X 100% Review
	X Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample;
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		X Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	X State Medicaid Agency	<input type="checkbox"/> Weekly	
	X Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		X Other: Specify: Every two years	

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Performance Measure: #2	Number and percentage of incidents for which an incident report was submitted within five business days of the discovery of an incident. The numerator is the total number of incidents reviewed for which an incident report was submitted within five business days of the discovery of the incident; the denominator is the total number of incidents reviewed.		
Data Source USTEPS Incident Reports	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	X 100% Review
	X Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample;
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		X Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	X State Medicaid Agency	<input type="checkbox"/> Weekly	
	X Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		X Other: Specify: Every two years	

Performance Measure: #3	Number and percentage of critical incidents for which prevention strategies were developed and implemented, when warranted. The numerator is the total number of critical incidents reviewed for which prevention strategies were developed and implemented, when warranted; the denominator is the total number of critical incidents reviewed that warranted prevention strategies.		
Data Source	Responsible Party for data collection/generation	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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USTEPS	<i>(check each that applies)</i>	<i>applies)</i>	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	X 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample;
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years	

Performance Measure: #4	# and % of critical incidents that required the development/implementation of prevention strategies in which the Administrative Case Manager followed up to verify the effectiveness of safeguards/interventions put in place. Numerator=Total # of critical incidents in compliance; Denominator=Total # of critical incidents that required the development/implementation of prevention strategies.		
Data Source USTEPS	Responsible Party for data collection/generation <i>(check each that applies)</i>	Frequency of data collection/generation: <i>(check each that applies)</i>	Sampling Approach <i>(check each that applies)</i>
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	X 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample;
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	

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		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years	

iii. **Sub-assurance: The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #1	Number and percentage of incidents identifying the use of restrictive interventions that were appropriately reported. The numerator is the total number of incidents reviewed identifying the use of restrictive interventions which were appropriately reported; the denominator is the total number of incidents reviewed that identified the use of restrictive interventions.		
Data Source USTEPS	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

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	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years	

iv. **Sub-assurance: The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #1	Number and percentage of participants who have been informed of incident reporting requirements, at a minimum of annually. The numerator is the total number of participants in the review sample who had been informed of the incident reporting requirements, at a minimum of annually; the denominator is the total number of participants reviewed.
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Data Source • USTEPS	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input checked="" type="checkbox"/> Other: Specify: Every two years	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years	

Performance Measure: #2
Number and percentage of participants who have been informed of the PD Waiver grievance procedures. The numerator is the total number of participants in the review sample which had been informed of the PD Waiver grievance procedures; the denominator is the total number of participants reviewed.

Data Source • USTEPS	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
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	<i>applies)</i>		
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error</i>
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: Every two years</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	
		<input checked="" type="checkbox"/> <i>Other: Specify: Every two years</i>	

Performance Measure: #3	Number and percentage of participants who have a back-up plan for the provision of essential services. The numerator is the total number of participants in the review sample who have a back-up plan in place; the denominator is the total number of participants reviewed.		
Data Source • USTEPS	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>

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	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error</i>
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: Every two years</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis (check each that applies)</i>	<i>Frequency of data aggregation and analysis: (check each that applies)</i>	
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	
		<input checked="" type="checkbox"/> <i>Other: Specify: Every two years</i>	

- v. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Referrals are made to Adult Protective Services and/or law enforcement according to State laws. Prevention strategies are developed and implemented when abuse, neglect or exploitation are reported. Health and welfare needs are addressed and steps are taken to resolve concerns in a timely manner and are documented in the record. In most cases, face to face visits are conducted to verify that all concerns are resolved. The SMA Quality Assurance Team conducts monitoring when notified by DSPD of a Level I critical incident or event.

The DSPD Quality Management Team conducts formal reviews of critical incidents at a minimum of every two years. When a fatality occurs, the Fatality Review Committee (Committee) reviews the death and submits a written report to the DSPD Director (Director). If follow-up is required, DSPD and its Director will respond to Committee accordingly.

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The SMA conducts annual and periodic reviews of the PD Waiver program. At a minimum, one comprehensive review will be conducted during the five year waiver cycle.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

Individual issues identified that affect the health and welfare of individual participants are addressed immediately. These issues are addressed in a variety of ways, and may include: a) direct contact for additional information if any, and b) informal discussion or formal (written) notice of adverse findings. The SMA will use discretion in determining notice requirements depending on the findings. Examples of issues requiring intervention by the SMA would include: overpayments; allegations or substantiated violations of health and safety; necessary involvement of APS and/or local law enforcement; or issues involving the State’s Medicaid Fraud Control Unit.

To assure the issue has been addressed, DSPD is required to report back to the SMA on the results of their interventions within designated time frames. These time frames are outlined in standard operating procedures or protocols or are stipulated on a case by case basis depending on the nature of a specific issue. A description of issues requiring immediate attention and outcomes are documented through the SMA Final Report.

Issues that are less immediate are corrected within designated time frames and are also documented through the SMA Final Report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and

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		<i>Ongoing</i>
		<i>X Other: Specify: Every two years</i>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

<input type="radio"/>	Yes <i>(complete remainder of item)</i>
<input checked="" type="radio"/>	No

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix H: Quality Improvement Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

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Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

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H.1 Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Trending is accomplished as part of the SMA annual waiver review for each performance measure that is assessed that year. Graphs display the percentage of how well the performance measures are met for each fiscal year. Graphs from the previous years are presented side by side with the current year's results, thus allowing for tracking and trending of performance measures. After a three-year cycle of reviews and annually thereafter, the performance measures will be analyzed to determine if, over time, a negative trend has occurred and if a systems improvement will address the problem. System improvement initiatives may be prioritized based on several factors including the health and welfare of participants, financial considerations, the intensity of the problem and the other performance measures relating to the specific assurance being evaluated.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of monitoring and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Other Specify:
	<i>Third year of waiver operation</i>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The SMA will establish a Quality Improvement Committee consisting of the SMA Quality Assurance Team, the DSPD PD Waiver Program Manager and the DSPD Quality Assurance Team among others. The team will meet to assess the results of the systems design changes. The success of the systems changes will be based on criteria that must be met to determine that the change has been accomplished and also criteria that will determine that the systems change has been sustained or will be sustained. The Quality Improvement Committee will determine the sustainability criteria. Results of systems design changes will be communicated to participants and their families, providers and others through the Medicaid Information Bulletin and the DSPD web site.

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- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy (QIS) is a dynamic document that is continuously evaluated each year by the SMA's Quality Assurance Team. The team evaluates the data collection process and makes changes as necessary to allow for accurate data collection and analysis. In addition the Quality Improvement Committee will evaluate the QIS after the third year of waiver operation. This committee will meet to discuss the elements of the QIS for each assurance, the findings relative to each performance measure and the contributions of all parties that conduct quality assurance of the PD Waiver.

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Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, Public Law 98-502.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES ROLE AND PROVIDER CONTRACTING REQUIREMENT

The Division of Services for People with Disabilities (DSPD) is the designated State agency responsible for planning and developing an array of services and supports for persons with disabilities living in Utah. State statute 62A-5-103, 1953 as amended, sets forth DSPD's authority and responsibility to:

1. Plan, develop and manage an array of services and supports for individuals with disabilities;
2. Contract for services and supports for persons with disabilities;
3. Approve, monitor and conduct certification reviews of approved providers; and
4. Develop standards and rules for the administration and operation of programs operated by or under contract with DSPD.

In accordance with DSPD's lead role and designated responsibilities, monies allocated for services for persons with disabilities are appropriated by the State Legislature to DSPD which in turn contracts with public and private providers for the delivery of services. To assure the proper accounting for State funds, DSPD enters into a written State contract with each provider. This State-specific requirement applies regardless of whether: 1) the State funds are used for State-funds only programs or are used to draw down FFP as part of a 1915(c) HCBS Waiver program, or 2) the target population includes Medicaid-eligible citizens. The State contract is the sole responsibility of, and is managed by, DSPD's parent agency, the Department of Human Services.

In the case where a portion of the annual Legislative appropriation is designated for use as State matching funds for the Medicaid 1915(c) HCBS Waiver described herein, DSPD certifies to the State Medicaid Agency (SMA), through an interagency agreement, that the State funds will be transferred to the SMA in the amount necessary to reimburse the State match portion of projected Medicaid expenditures paid through the MMIS system for waiver services.

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As a result of the State's organizational structure described above:

1. All providers participating in this 1915(c) HCBS PD Waiver must: a) Fulfill the DSPD State contracting requirement as one of the waiver provider qualifications related to compliance with State law, and b) agree to bill the MMIS directly or voluntarily reassign payment to DHS/DSPD.
2. The State Medicaid Agency reimburses DSPD for any interim payments that are made for legitimate waiver service claims during the time the clean claim is being processed through the MMIS system.
3. The State Medicaid Agency receives from DSPD the State matching funds associated with the waiver expenditures prior to the State Medicaid Agency's drawing down Federal funds.
4. The State Medicaid Agency approves all proposed rules, policies and other documents related to 1915(c) waivers prior to adoption by the DSPD policy board.

SMA ROLE AND PROVIDER CONTRACT REQUIREMENT

The SMA, in fulfillment of its mandated authority and responsibilities related to the 1915(c) HCBS waiver programs, retains responsibility for negotiating a Medicaid Provider Agreement with each provider of waiver services. Unlike the DSPD State contract required of all providers of services to persons with disabilities who receive State monies, the Medicaid Provider Agreement is specific to providers of Medicaid funded services.

DHS/DSPD requires submission of all mandatory State Audit requirements imposed on contracted providers by the State Auditor's Office. This information is a requirement of the contract entered into by DSPD and the provider.

During annual contract reviews, the DSPD Quality Management team reviews 100% of provider contracts. A component of the reviews includes a review of payment histories and the documentation to support those payments. This ensures the services were received and the correct payment was made.

JOINT DSPD STATE CONTRACT/SMA PROVIDER AGREEMENT

Personal Attendant providers present challenges to the effective and efficient operation of the PD Waiver in particular. It is anticipated that this will be the sole instance in which individuals serving as Personal Attendants will be associated with the Medicaid program as enrolled providers. It is also anticipated that the number of participating Personal Attendants will be significant, thus imposing a substantial administrative effort to negotiate required contracts and agreements. Therefore, for purposes of the effective management of Personal Attendant waiver service providers only, a joint DSPD State Contract/SMA Provider Agreement (Joint Agreement) has been developed. The Joint Agreement complies with the content requirements of Medicaid Provider Agreement and requires the signature of the Personal Attendant waiver service provider, DSPD, and the SMA. The effective date of the contract is the date the document is signed by all three parties.

Upon enrollment into the PD Waiver all individuals receiving services through the self-administered services method are informed of their responsibility and sign a letter of agreement to monitor and manage all employee(s) hours and wages. They are required to receive, sign and copy all employee(s) timesheets and submit them to the FMS agent twice a month. The participant is responsible to verify the accuracy of all hours billed by the employee(s).

Each month the administrative case manager reviews the billing statement and a monthly budget report generated by DSPD.

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INTERAGENCY AGREEMENT FOR OPERATIONS AND ADMINISTRATION OF THE HCBS WAIVER

An interagency agreement between the SMA and DSPD sets forth the respective responsibilities for the administration and operation of this waiver. The agreement delineates the SMA's overall responsibility to provide management and oversight of the waiver including review and approval of all waiver related rules and policies to ensure compliance with Medicaid HCBS waiver rules and regulations. The agreement also delineates DSPD's roles in relation to the statutory responsibilities to develop the State's program for persons with disabilities. The nature of the agreement enhances provider access to the Medicaid program and quality assurance of services as well as defines the fiscal relationship between the two agencies.

The major components of the agreement are:

1. Purpose and Scope;
2. Authority;
3. Definitions;
4. Waiver Program Administration and Operation Responsibilities;
5. Claims Processing;
6. Payment for Delegated Administrative Duties (including provisions for State match transfer);
7. Role Accountability and FFP Disallowances; and
8. Coordination of DHS Policy Development as it relates to Implementation of the Medicaid Program.

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. **Methods for Discovery: Financial Accountability Assurance**
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program
- i. **Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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<p>Performance Measure: #1</p>	<p>Number and percentage of payments in a representative sample paid for services identified on a participant’s service plan and in total; do not exceed the participant’s annual budget. The numerator is the total number of payments made for waiver services which were in compliance; the denominator is the total number of payments in the review sample.</p>		
<p>Data Source</p> <ul style="list-style-type: none"> • Participant Claims Data • PCSP • Participant Budgets 	<p>Responsible Party for data collection/generation (check each that applies)</p>	<p>Frequency of data collection/generation: (check each that applies)</p>	<p>Sampling Approach (check each that applies)</p>
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
<p>Data Aggregation and Analysis</p>	<p>Responsible Party for data aggregation and analysis (check each that applies)</p>	<p>Frequency of data aggregation and analysis: (check each that applies)</p>	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and	

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		<i>Ongoing</i>	
		<input checked="" type="checkbox"/> <i>Other: Specify:</i> Every two years	

Performance Measure: #2	Number and percentage of participant claims in a representative sample paid for services that use approved PD Waiver codes. The numerator is the total number of participant claims in the review sample which paid for PD Waiver services using approved PD Waiver codes; the denominator is the total number of participant claims in the review sample.		
Data Source	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
<ul style="list-style-type: none"> • Participant Claims Data • PCSP • Participant Budgets 			
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval 95% Confidence Level, 5% Margin of Error</i>
	<input type="checkbox"/> <i>Other: Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i>
		<input type="checkbox"/> <i>Other: Specify:</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	

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	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	
		<input checked="" type="checkbox"/> <i>Other: Specify: Every two years</i>	

<i>Performance Measure: #3</i>	Number and percentage of provider claims submitted and processed through the CAPS in a representative sample that match the DSPD claims submitted and processed through the MMIS. The numerator is the total number of provider claims in compliance; the denominator is the total number of provider claims submitted and processed through CAPS in the review sample.		
<i>Data Source</i>	<i>Responsible Party for data collection/generation</i> (check each that applies)	<i>Frequency of data collection/generation:</i> (check each that applies)	<i>Sampling Approach</i> (check each that applies)
<ul style="list-style-type: none"> CAPS claims payment history report MMIS claims payment history report 			
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error</i>
	<input type="checkbox"/> <i>Other: Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i>
		<input type="checkbox"/> <i>Other: Specify:</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and</i>	<i>Frequency of data aggregation and</i>	

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	<i>analysis</i> (check each that applies)	<i>analysis:</i> (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input checked="" type="checkbox"/> Other: Specify: Every two years	

Performance Measure: #4	Number and percentage of recoupments in a representative sample identified and processed correctly through MMIS with an audit trail of the claim paid in error and overpayments are returned to the federal government within required time frames. The numerator is the total number of recoupments in compliance; the denominator is the total number of recoupments identified in the review sample.		
Data Source	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
<ul style="list-style-type: none"> • Participant Claims Data • SMA QA Review • CMS 64 Report 			
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Groups
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe

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Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other: Specify:	

ii. **Sub-assurance: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #1	Number and percentage of participant claims in a representative sample paid for services that use approved PD Waiver rates. The numerator is the total number of participant claims in the review sample which paid for PD Waiver services using approved PD Waiver rates; the denominator is the total number of participant claims in the review sample.		
Data Source	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
<ul style="list-style-type: none"> • Participant Claims Data • PCSP • Participant Budgets 			
	<input checked="" type="checkbox"/> State Medicaid	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

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	<i>Agency</i>		
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval 95% Confidence Level, 5% Margin of Error</i>
	<input type="checkbox"/> <i>Other: Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i>
		<input type="checkbox"/> <i>Other: Specify:</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
<i>Data Aggregation and Analysis</i>	<i>Responsible Party for data aggregation and analysis</i> <i>(check each that applies)</i>	<i>Frequency of data aggregation and analysis:</i> <i>(check each that applies)</i>	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	
		<input checked="" type="checkbox"/> <i>Other: Specify: Every two years.</i>	

<i>Performance Measure: #2</i>	Number and percentage of providers in a representative sample that receive and retain 100% of amounts claimed for PD Waiver services. The numerator is the total number of providers in the review sample which receive and retain 100% of amounts claimed for PD Waiver services; the denominator is the total number of providers in the review sample.		
<i>Data Source</i>	<i>Responsible Party for data collection/generation</i> <i>(check each that applies)</i>	<i>Frequency of data collection/generation:</i> <i>(check each that applies)</i>	<i>Sampling Approach</i> <i>(check each that applies)</i>
<ul style="list-style-type: none"> CAPS claims payment history report 			

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<ul style="list-style-type: none"> MMIS claims payment history report Provider Claims 			
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error</i>
	<input type="checkbox"/> <i>Other: Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Groups</i>
		<input type="checkbox"/> <i>Other: Specify:</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>	
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	
		<input checked="" type="checkbox"/> <i>Other: Specify: Every two years.</i>	

iii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The SMA conducts an annual review of the PD Waiver for each of the five waiver years. Due to available resources, at a minimum one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews.

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The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DSPD and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to five.

Contract analysts from DSPD will monitor monthly usage of approved services to ensure that billed services are within the participant’s budget. Adjustments will be made to the service plan and budgets when warranted by changes in participant needs. The Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS) will assist with preventing overpayments that are over and above a participant’s individual budget by providing reports to administrative case managers to review when claims are either significantly under or over budget.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

Recoupment of Funds:

- When payments are made for services not identified on the PCSP: The SMA will require a recoupment of unauthorized paid claims.
- When the amount of payments made exceed the amount identified on the annual budget: The SMA will require a recoupment of unauthorized paid claims.
- When payments are made for services based on a coding error: The coding error will be corrected by withdrawing the submission of the claim and submitting the correct code for payment.

The recoupment of funds will proceed as follows:

1. The SMA will complete a Recoupment of Funds Form that indicates the amount of the recoupment and send it to DSPD.
2. DSPD will review the Recoupment of Funds Form and return the signed form to the SMA.
3. Upon receipt of the Recoupment of Funds Form, the SMA will submit the recoupment to Medicaid Operations.
4. Medicaid Operations will reprocess the MMIS claims to reflect the recoupment.
5. Overpayments are returned to the Federal government within required time frames.

ii. Remediation Data Aggregation

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Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> Other: Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

<input type="radio"/>	Yes (complete remainder of item)
<input checked="" type="radio"/>	No

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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APPENDIX I-2: Rates, Billing and Claims

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

There are four principal methods used in setting the DHS Maximum Allowable Rate level. Each method is designed to determine a fair market rate. Four different methodologies are in place to accommodate the different market factors that exist for different types of services. With all new services and any inflationary increases or decreases to existing service rates, the SMA reviews and approves all proposed rates prior to the rates being loaded into the MMIS. Payment rates may also been subject to changes mandated by the State Legislature.

Adjustments to the following processes may be deemed necessary on occasion to comply with funding requirements. Additionally, the process may be adjusted on occasion to account for common factors such as the geographical location of service delivery, absentee factors or division budget constraints, etc.

1. Existing Market Survey or Cost Survey of Current Providers.

This methodology surveys existing providers to determine their actual cost to render a service. This would include direct labor, supervision, administration, non-labor costs allocated to the purchased service and the basis of cost allocations. The surveys are designed to assure all providers are reporting costs in a standardized manner and within allowable cost parameters established by DHS. Surveys are examined to determine if cost definitions, allocations and reporting are consistent among respondents and accurately include reasonable costs of business. The rate is set using a measure of central tendency such as median, mode or weighted average and adjusted if necessary to reflect prevailing market conditions. (For example, a large provider may distort data and smaller providers may have substantially different costs. Failure to adjust for market realities may result in lack of available providers if the rate is set too low, or unnecessarily paying too much if the rate is set too high.)

2. Component Cost Analysis

The estimated cost of each of the various components of a service code (rent, treatment, administration, direct labor, non-labor costs allocated to the service, etc.) are determined and added together to determine a provisional rate. This method is often used for a new or substantially modified service that does not currently exist in the market place. Provisional rates are designed to determine a fair market rate until historical data becomes available. At a later date when historical cost data does become available a market survey may be undertaken to confirm or adjust the rate.

3. Comparative Analysis

This method may be used when similar services exist. Adjustments are made to reflect any differences in a new service. Where possible, and to provide consistency of payments in the provider community, rates are set to maintain common rates for common services purchased by various agencies. If a proposed service duplicates an existing service being used by another agency

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or program, the existing rate may be used to provide consistency of payments in the provider community if the companion agency rate is considered to be in line with the market.

4. Community Price Survey

Where a broad based market exists for a service outside of DHS, existing service providers may be surveyed to determine the prevailing market price for the service. Again, measures of central tendency such as median, mode or weighted average are used and adjusted if necessary to reflect prevailing market.

Payment rates are made available to participants so that they can make informed choices regarding their self-administered services in two ways: 1) Administrative case managers provide payment rate information to participants during their enrollment in self-administered services; and 2) Annually, DSPD sends an approved payment rate letter to the FMS providers. The FMS providers then communicate this information to all participants they serve.

The method used to establish the rate for each waiver service is provided below, along with information regarding how the service is reimbursed to the provider:

Financial Management Services - Comparative Analysis - Fixed/Predetermined

Personal Assistance Services - Comparative Analysis - Fixed/Predetermined

Personal Emergency Response System (PERS) - Existing Market Survey - Fixed/Predetermined

Specialized Medical Equipment and Supplies - Community Price Survey - Fixed/Predetermined

In July 2013 the State submitted a request to have Specialized Medical Equipment added as an available service. Two variants of the service were proposed:

Specialized Medical Equipment and Supplies – Purchase, Installation, Removal, Replacement and Repair

Specialized Medical Equipment and Supplies – Monthly Fee

At that time, five providers responded to a community price survey allowing the State to determine a prevailing market rate and establish its own Maximum Allowable Rate for each variant of this specific service.

For all other services apart from Specialized Medical Equipment the State will, by the end of calendar year 2017, complete a review and provide detail of its rate setting methodology using current data from 2012 or later.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

For Providers who Voluntarily Reassign Payment to DHS/DSPD:

Requests for payments from the contracted providers are submitted to DHS/DSPD on form 520; payments are then made to the providers. DHS/DSPD submits billing claims to the Utah Department of Health (DOH) for reimbursement.

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For individuals self-directing their personal attendant(s), the participant submits their staff time sheet(s) to the FMS Agent. The FMS Agent pays the claim(s) and submits a bill to DHS/DSPD on form 520. DHS/DSPD pays the FMS Agent and then submits the billing claim to DOH for reimbursement.

For providers who bill the MMIS directly:

Providers submit billing prior authorization forms to DSPD prior to submitting the claims to MMIS. DSPD will review the billing prior authorization forms submitted by the provider and will authorize the provider to bill the MMIS as long as the claims submitted on the billing prior authorization form are consistent with the service type, amount, frequency and duration as listed on the PCSP and budget.

- If the services listed on the billing prior authorization form are consistent with the PCSP and budget, DSPD will submit a notice of approval to the provider authorizing them to bill the MMIS.
- If the services listed on the billing prior authorization form are not consistent with the PCSP or budget, billing for services will not be authorized by DSPD. DSPD will submit the denial notice to the provider that will include an explanation of why the prior authorization was denied.

Once DSPD has approved the billing prior authorization forms, the provider will then submit claims directly through the States' MMIS.

c. Certifying Public Expenditures (select one):

<input checked="" type="checkbox"/>	No. State or local government agencies do not certify expenditures for waiver services.
<input type="checkbox"/>	Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid. <i>Select at least one:</i>
<input type="checkbox"/>	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). <i>(Indicate source of revenue for CPEs in Item I-4-a.)</i>
<input type="checkbox"/>	Certified Public Expenditures (CPE) of Local Government Agencies. Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). <i>(Indicate source of revenue for CPEs in Item I-4-b.)</i>

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d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant’s approved service plan; and, (c) the services were provided:

1. A participant's Medicaid eligibility is determined by the Office of Health and Eligibility within the Department of Workforce Services. The information is entered into the eligibility system which automates Medicaid eligibility decisions, benefits amounts, participants' notices and administrative reports. The eligibility system also interfaces with other governmental agencies such as, Social Security, Employment Security, and the Internal Revenue Service. The system is a Federally-Approved Management Information System (FAMIS). In Utah, the following programs are accessed through the eligibility system: Aid to Families with Dependent Children (AFDC), Medicaid, Food Stamps, and two state-administered programs - General Assistance and the Primary Care Network (PCN). MMIS accesses the eligibility system to ensure the participant is Medicaid eligible before payment of claims is made. Both CAPS (DHS provider payment system) and MMIS contain edits to help ensure that no payment is ever rendered to Medicaid ineligible recipients or providers. CAPS queries the eligibility system for each claim to determine Medicaid eligibility before that claim is submitted to MMIS for reimbursement. Claims for which Medicaid eligibility is not verified are excluded from the batch-processed claims submitted by CAPS to MMIS for FFP reimbursements. DHS/DSPD providers are paid through CAPS, and only after Medicaid eligibility of both recipient and provider is verified through MMIS is federal participation received by DHS/DSPD.

2. Post-payment reviews are conducted by the Medicaid agency; reviews of a sample of PCSPs and Medicaid claims histories to ensure: (1) all of the services required by the participant are identified in the PCSP, (2) that the participant is receiving the services identified in the PCSP and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the PCSP. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

3. The SMA will perform an annual post payment review of claims that are paid to providers through CAPS. The review will verify that the rates paid to providers through CAPS are equal to the rates paid to DSPD through the MMIS.

Also, in addition to authorizing time sheets, each month the participant receives a report from the FMS agent detailing the service utilization. This report can be compared to the services that were actually provided.

The administrative case manager is responsible to have frequent and ongoing interactions with waiver participants and is expected to monitor service utilization and assure services provided continue to meet the participant’s needs on an ongoing basis.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

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APPENDIX I-3: Payment

a. Method of payments — MMIS (*select one*):

<input type="radio"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="radio"/>	<p>Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.</p>
<input checked="" type="radio"/>	<p>Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:</p> <p>a) The Waiver services that are not paid through an approved MMIS</p> <p>Payment for all waiver services are made through an approved MMIS eventually. However, for providers that voluntarily reassign payment to the Department of Human Services (DHS), initially payments for waiver services are paid to providers through the DHS Contract, Approval and Provider System (CAPS).</p> <p>(b) The process for making such payments and the entity that processes payments</p> <p>Waiver services providers bill the DHS using a paper claim that is entered into the CAPS system. The CAPS system has edits in place that will deny payment for reasons such as exceeding the maximum allowable number of approved units or maximum allowable rates, etc. Providers are reimbursed by DHS with either a paper check or an electronic funds transfer as per the provider's preference. DHS then submits a tape of all claims paid through CAPS to the SMA. The claims are then entered into the MMIS for payment. The SMA makes payment to DHS through an Intergovernmental Transfer of Funds (IGT). Each claim is individually identifiable at the level of the participant, provider, HCPCS and units of service paid.</p> <p>(c) How an audit trail is maintained for all State and Federal funds expended outside the MMIS</p> <p>The audit trail outside the MMIS is maintained in CAPS.</p> <p>(d) The basis for the draw of Federal funds and claiming of these expenditures on the CMS-64</p> <p>As stated previously all waiver service payments are eventually made through an approved MMIS and this is the basis for the draw of Federal funds and claiming of these expenditures on the CMS-64.</p> <p>CAPS along with supporting documentation and claim information processed through MMIS</p>

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	<p>provide audit support. Each PCSP must specify the amount, frequency and duration of prescribed services and is documented in the Utah Systems for Tracking Eligibility, Planning and Services (USTEPS) by administrative case managers and result in payment authorizations within CAPS. Payment authorizations result in the generation of provider billings. Provider claims are accompanied by eligibility codes that detail whether services qualify for FFP. Claims for services rendered under Medicaid eligibility are then ported to MMIS where recipient and provider eligibility are verified and claims that are determined to be eligible for FFP result in reimbursement to DHS/DSPD. Individual claim information is documented in MMIS.</p> <p>Utah DOH/DSPD IGT Process</p> <ol style="list-style-type: none"> 1. The Department of Health (DOH) estimates the state seed amount for the quarter. 2. The DOH sends the IGT request to DHS for the estimated amount. 3. DHS processes the IGT request. 4. DHS approves the request. 5. DOH receives the funds before the start of the quarter. 6. At the end of the quarter, DOH determines the actual seed amount based on the paid claims. 7. The DOH sends the IGT request to DHS for the actual paid amount. 8. DHS approves the IGT request and DOH receives the funds. 9. DOH refunds the estimated amount to DHS via an IGT.
○	<p>Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.</p> <p>Describe how payments are made to the managed care entity or entities:</p>

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

<input type="checkbox"/>	The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
<input type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
X	<p>The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.</p> <p>Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:</p> <p>DHS/DSPD serves as the governmental entity that pays for waiver claims for providers who voluntarily reassign payment to DHS and DHS will pay for all services provided by the waiver when they are delivered by qualified providers according to the PCSP. DSPD obtains all of the claims for payment for services delivered directly from contract providers on the form 520. It reviews the claims for accuracy and all approved claims are paid directly to the providers by DSPD. DSPD then submits billing claims to DOH for reimbursement. The DHS Form 520 is a paper billing invoice form that is either generated by the CAPS billing system and sent to contracted providers for their review and approval, or else is generated directly by contracted providers. The reviewed and approved Form 520 is then submitted to DSPD fiscal</p>

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	<p>personnel for additional review and approval and it is then submitted to CAPS by DSPD data entry personnel for payment.</p> <p>DSPD has internal controls in place to assure providers paid through the CAPS system receive payment that is equal to the payment DSPD receives from DOH including a comparison of DOH's MMIS Reference File rates with DSPD's CAPS rates for the same service, as per the DOH rate sheet provided each year. A comparison of MMIS HCPCS code/rate information with corresponding CAPS service code/rate information is implemented and documented via screen prints on a copy of a rate chart spreadsheet. This is completed before the beginning of each fiscal year when rates are generally adjusted, but a periodic review of CAPS to MMIS rates is completed throughout the year. Post rate adjustment billing detail is reviewed closely to ensure the agreed rates are correct on the claims submitted for reimbursement, as is the claims reimbursement detail.</p> <p>The SMA will perform an annual post payment review of claims that are paid to providers through CAPS. The review will verify that the rates paid to providers through CAPS are equal to the rates paid to DSPD through the MMIS.</p> <p>The rates schedules are coordinated between DOH and DSPD and the individual systems. In the event of a retro effective date, DOH and DSPD would coordinate the rate change in their system and DHS resubmit the previously paid claims through the MMIS system to be reprocessed.</p> <p>In the event of a retro effective rate change the following would occur:</p> <ol style="list-style-type: none"> 1. The rates schedules would be coordinated between DOH and DSPD. 2. Providers would be notified of the rate change. 3. DSPD would have the rate set to the correct amount in CAPS and the claims would be reprocessed reflecting the new rate. 4. Providers payments would reflect the new rate. 5. The MMIS system would have the rate set at the correct amount and the affected claims would be reprocessed. 6. DSPD would receive their IGT that reflects the new rate.
<input type="checkbox"/>	<p>Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.</p> <p>Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.</p>

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

X	No. The State does not make supplemental or enhanced payments for waiver services.
O	Yes. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the

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	waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

<input checked="" type="checkbox"/>	No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
<input type="checkbox"/>	Yes. State or local government providers receive payment for waiver services. Complete item I-3-e. Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish. <i>Complete item I-3-e.</i>

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

<input type="checkbox"/>	The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
<input type="checkbox"/>	The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
<input type="checkbox"/>	The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

<input checked="" type="checkbox"/>	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
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<input type="radio"/>	<p>Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.</p> <p>Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.</p>

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

<input type="radio"/>	<p>No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.</p>
<input checked="" type="radio"/>	<p>Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).</p> <p>Specify the governmental agency (or agencies) to which reassignment may be made.</p> <p>DHS is the governmental agency to which reassignment is made.</p>

ii. Organized Health Care Delivery System. *Select one:*

<input checked="" type="radio"/>	<p>No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.</p>
<input type="radio"/>	<p>Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.</p> <p>Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:</p>

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

<input checked="" type="radio"/>	<p>The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.</p>
<input type="radio"/>	<p>The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the</p>

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	<p>State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.</p>
○	<p>This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.</p>

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APPENDIX I-4: Non-Federal Matching Funds

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

<input type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid agency
<input checked="" type="checkbox"/>	<p>Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency. If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:</p> <p>State tax revenues, or general funds, are appropriated directly to DHS by the Utah State Legislature. DSPD, which resides within DHS, receives the appropriated funds. DSPD transfers the funds to the SMA via an Intergovernmental Transfer (IGT). This prepayment transfer is based on estimates for the upcoming quarter and takes place approximately 15 days before each new quarter. At the end of each quarter, the SMA will perform a reconciliation of the actual State match obligation and the prepaid amount.</p>
<input type="checkbox"/>	<p>Other State Level Source(s) of Funds. Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:</p>

- b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select one:*

<input checked="" type="checkbox"/>	Not Applicable. There are no local government level sources of funds utilized as the non-federal share.
<input type="checkbox"/>	<p>Applicable <i>Check each that applies:</i></p>
<input type="checkbox"/>	<p>Appropriation of Local Government Revenues. Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:</p>
<input type="checkbox"/>	<p>Other Local Government Level Source(s) of Funds. Specify: (a) the source of funds; (b) the local government entity or agency receiving funds;</p>

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	and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

- c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds . *Select one:*

<input checked="" type="radio"/>	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.
<input type="radio"/>	The following source(s) are used. <i>Check each that applies.</i>
<input type="checkbox"/>	Health care-related taxes or fees
<input type="checkbox"/>	Provider-related donations
<input type="checkbox"/>	Federal funds
	For each source of funds indicated above, describe the source of the funds in detail:

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APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

<input checked="" type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual.
<input type="radio"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

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APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.

Select one:

<input checked="" type="checkbox"/>	<p>No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.</p>
<input type="checkbox"/>	<p>Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.</p> <p>The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>

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APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

- a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

<input checked="" type="checkbox"/>	No. The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="checkbox"/>	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

i. **Co-Pay Arrangement**

Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>Specify:</i>

ii **Participants Subject to Co-pay Charges for Waiver Services.**

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

- iii. **Amount of Co-Pay Charges for Waiver Services.** The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	Basis

State:	
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iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

<input type="radio"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

<input checked="" type="checkbox"/>	No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
<input type="checkbox"/>	Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded; and (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care (<i>specify</i>):		Nursing Facility					
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Column 7 less Column 4)
1	\$17,235.61	\$8,895.37	\$26,130.98	\$60,622.87	\$5,797.68	\$66,420.55	\$40,289.58
2	\$17,588.20	\$9,073.28	\$26,661.47	\$61,835.33	\$5,913.63	\$67,748.96	\$41,087.49
3	\$17,941.05	\$9,254.74	\$27,195.79	\$63,072.04	\$6,031.91	\$69,103.94	\$41,908.15
4	\$18,294.28	\$9,439.84	\$27,734.11	\$64,333.48	\$6,152.54	\$70,486.02	\$42,751.91
5	\$18,647.87	\$9,628.63	\$28,276.51	\$65,620.15	\$6,275.60	\$71,895.74	\$43,619.24

State:	
Effective Date	

Appendix J-2: Derivation of Estimates

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	140	140	140
Year 2	140	140	140
Year 3	140	140	140
Year 4 (only appears if applicable based on Item 1-C)	140	140	140
Year 5 (only appears if applicable based on Item 1-C)	140	140	140

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-a.

Average Length of Stay (LOS) = 44 336 days
 - Used the actual LOS from fiscal 2014years 2013-2015

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

- All calculations are based off the actual amounts 4from FY2013-20154
- Price per unit was increased 2% each year.
- Units Per User is the average units per user for 4FY2013-2015 rounded to the next whole number
- Estimates may have had slight adjustments if trending data indicated that they may not be reflective of anticipated utilization

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

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- All calculations are based off the actual amounts for FY2014FY2013-2015
- Each subsequent year was increased 2%
- The state utilizes the MMIS Categories of Service and Provider Type functionality to account for and exclude the costs of prescribed drugs from D'

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- Used actual average nursing home cost per day for FY2014FY2013-2015 and multiplied by actual PD Waiver LOS to get fiscal year 2015 and 2016 base estimates and then increased by 2% to get waiver year one (fiscal year 2017).
- Each subsequent year was increased 2%

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- Used actual average nursing home cost per day for FY2014FY2013-2015 and multiplied by actual PD Waiver LOS to get fiscal year 2016 base estimates and then increased by 2% to get waiver year one (fiscal year 2017).
- Each subsequent year was increased 2%

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Personal Attendant Services	<u>manage components</u>
Consumer Preparation Services	<u>manage components</u>
Financial Management Services	<u>manage components</u>
Local Area Support Coordination Liaison	<u>manage components</u>
Personal Emergency Response Systems (PERS)	<u>manage components</u>
Specialized Medical Equipment and Supplies – Monthly Fee	<u>manage components</u>
Specialized Medical Equipment and Supplies –	<u>manage components</u>

State:	
Effective Date	

Purchase, Installation, Removal, Replacement and Repair	
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State:	
Effective Date	

d. **Estimate of Factor D.** *Select one:* Note: Selection below is new.

<input checked="" type="radio"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input type="radio"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. **Estimate of Factor D – Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit	Total Cost
	Daily	1	365	\$94.08	\$34,339.20
Personal Attendant Services	15 Minute	138	5672	\$2.93	\$2,293,416.48
Financial Management Services	Monthly	140	11	\$42.33	\$65,188.20
Personal Emergency Response Services - Monthly Monitoring	Monthly	56	11	\$30.29	\$18,658.64
Personal Emergency Response Services - Purchase	Per Episode	1	1	\$208.08	\$208.08
Personal Emergency Response Services - Install & Testing	Per Episode	2	1	\$24.28	\$48.56
Specialized Medical Equipment - Monthly	Monthly	2	2	\$52.02	\$208.08
Specialized Medical Equipment - Purchase/Install/Removal/Replacement	Per Episode	3	7	\$43.70	\$917.70
GRAND TOTAL:					\$2,412,984.94
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					140
FACTOR D (Divide grand total by number of participants)					\$17,235.61
AVERAGE LENGTH OF STAY ON THE WAIVER					336

State:	
Effective Date	

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Personal Attendant Services	Daily	1	365	\$95.96	\$35,025.40
Personal Attendant Services	15 Minute	138	5672	\$2.99	\$2,340,380.64
Financial Management Services	Monthly	140	11	\$43.18	\$66,497.20
Personal Emergency Response Services - Monthly Monitoring	Monthly	56	11	\$30.90	\$19,034.40
Personal Emergency Response Services - Purchase	Per Episode	1	1	\$212.24	\$212.24
Personal Emergency Response Services - Install & Testing	Per Episode	2	1	\$24.77	\$49.54
Specialized Medical Equipment - Monthly	Monthly	2	2	\$53.06	\$212.24
Specialized Medical Equipment - Purchase/Install/Removal/Replacement	Per Episode	3	7	\$44.57	\$935.97
GRAND TOTAL:					\$2,462,347.63
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					140
FACTOR D (Divide grand total by number of participants)					\$17,588.20
AVERAGE LENGTH OF STAY ON THE WAIVER					336

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Personal Attendant Services	Daily	1	365	\$97.88	\$35,726.20
Personal Attendant Services	15 Minute	138	5672	\$3.05	\$2,387,344.80
Financial Management Services	Monthly	140	11	\$44.04	\$67,821.60
Personal Emergency Response Services - Monthly Monitoring	Monthly	56	11	\$31.52	\$19,416.32
Personal Emergency Response Services - Purchase	Per Episode	1	1	\$216.48	\$216.48
Personal Emergency Response Services - Install & Testing	Per Episode	2	1	\$25.27	\$50.54
Specialized Medical Equipment - Monthly	Monthly	2	2	\$54.12	\$216.48
Specialized Medical Equipment - Purchase/Install/Removal/Replacement	Per Episode	3	7	\$45.46	\$954.66
GRAND TOTAL:					\$2,511,747.08
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					140
FACTOR D (Divide grand total by number of participants)					\$17,941.05
AVERAGE LENGTH OF STAY ON THE WAIVER					336

State:	
Effective Date	

Waiver Year: Year 4 (only appears if applicable based on Item 1-C)					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Personal Attendant Services	Daily	1	365	\$99.84	\$36,441.60
Personal Attendant Services	15 Minute	138	5672	\$3.11	\$2,434,308.96
Financial Management Services	Monthly	140	11	\$44.92	\$69,176.80
Personal Emergency Response Services - Monthly Monitoring	Monthly	56	11	\$32.15	\$19,804.40
Personal Emergency Response Services - Purchase	Per Episode	1	1	\$220.81	\$220.81
Personal Emergency Response Services - Install & Testing	Per Episode	2	1	\$25.78	\$51.56
Specialized Medical Equipment - Monthly	Monthly	2	2	\$55.20	\$220.80
Specialized Medical Equipment - Purchase/Install/Removal/Replacement	Per Episode	3	7	\$46.37	\$973.77
GRAND TOTAL:					\$2,561,198.70
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					140
FACTOR D (Divide grand total by number of participants)					\$18,294.28
AVERAGE LENGTH OF STAY ON THE WAIVER					336

State:	
Effective Date	

Waiver Year: Year 5 (only appears if applicable based on Item 1-C)					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Personal Attendant Services	Daily	1	365	\$101.84	\$37,171.60
Personal Attendant Services	15 Minute	138	5672	\$3.17	\$2,481,273.12
Financial Management Services	Monthly	140	11	\$45.82	\$70,562.80
Personal Emergency Response Services - Monthly Monitoring	Monthly	56	11	\$32.79	\$20,198.64
Personal Emergency Response Services - Purchase	Per Episode	1	1	\$225.23	\$225.23
Personal Emergency Response Services - Install & Testing	Per Episode	2	1	\$26.30	\$52.60
Specialized Medical Equipment - Monthly	Monthly	2	2	\$56.30	\$225.20
Specialized Medical Equipment - Purchase/Install/Removal/Replacement	Per Episode	3	7	\$47.30	\$993.30
GRAND TOTAL:					\$2,610,702.49
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					140
FACTOR D (Divide grand total by number of participants)					\$18,647.87
AVERAGE LENGTH OF STAY ON THE WAIVER					336

State:	
Effective Date	

