Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Submitted by:

Submission Date:	

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment) Include population served and broad description of the waiver program:

Brief Description:
Major Changes: • Increase in the Limit of Clients Served   ○ The limitation on the number of clients served annually will be increased from 1400 to 1700 for fiscal year 2014 and fiscal year 2015.

State:	
Effective Date	

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 State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

State:	
Effective Date	

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. **Waiver Title** (*optional*): New Choices Waiver

C. **Type of Request** *(select only one)*:

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
◉	**Renewal (5 Years) of Waiver #**	0439	
○	**Amendment to Waiver #**		

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

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
◉	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 **Proposed Effective Date:** July 1, 2013

E.2 **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)*:

☐	Hospital *(select applicable level of care)*	
	○	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:
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
☑	Nursing Facility *(select applicable level of care)*	
	○	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:
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

State:	
Effective Date	

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

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

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 Utah New Choices Waiver focuses on deinstitutionalization of Medicaid recipients residing in institutional settings (nursing facilities) into home and community based services settings. The waiver program is open to individuals who meet Medicaid financial eligibility criteria, nursing facility level of care criteria, and special targeting criteria. The special targeting criteria limits participation to individuals who at the time of application:

1. are 18 years of age or older;
2. (a) are receiving nursing facility care and have been continuously receiving nursing facility care for a minimum of 90 days prior to admission; or
   (b) are receiving assisted living facility care and have been continuously receiving assisted living facility care for a minimum of 180 days prior to admission; or
   (c) are receiving Medicare or Medicaid reimbursed care in another type of Utah licensed medical institution that is not an institution for mental disease (IMD), on an extended stay of at least 30 days, and will discharge to a nursing facility for an extended stay of at least 60 days absent enrollment into the waiver program; or
   (d) are receiving Medicaid reimbursed services through another of Utah's 1915(c) waivers and have been identified in need of immediate (or near immediate) nursing facility admission absent enrollment into this waiver program; or
   (e) have previously been enrolled in the New Choices Waiver but were disenrolled from the waiver due to receipt of a lump sum payment or other financial settlement that resulted in loss of Medicaid financial eligibility.
3. For individuals leaving acute care hospitals, specialty hospitals (non IMD), and Medicare skilled nursing facilities, participation is limited to those receiving a medical, non-psychiatric level of care.
4. Individuals who meet the intensive skilled level of care as provided in R414-502 are not eligible for participation in the New Choices Waiver.
5. Individuals who meet the level of care criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-ID) as provided in R414-502 are not eligible for participation in the New Choices Waiver.

Recognizing the focus on deinstitutionalization, the waiver offers a full array of service to address the needs of individuals transitioning from institutional settings.

Waiver services allow and support individuals' choice of the method in which they receive services. Several waiver services are available to individuals through a consumer directed arrangement, while individuals preferring a more traditional method of service delivery will have the ability to choose this option as well.

The New Choices Waiver does not provide services to individuals in IMDs. The State assures that facilities in which services are provided are adequate to meet the health and welfare of the individuals served. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when provided as part of respite services in a facility approved by the State that is not a private residence. Wherever a PIHP, PAHP or a MCO is a provider of waiver services these providers will only operate on a fee-for-service basis for the provision of waiver services. The State Medicaid Agency assures that it has protocols and safeguards to prevent any potential duplication of services available through other authorities.

State:	
Effective Date	

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)*:

⦿	The waiver provides for participant direction of services. *Appendix E is required*.
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed*.

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 overall systems improvement 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.

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)*:

⦿	Yes
○	No
○	Not applicable

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

○	**Yes** *(complete remainder of item)*
⦿	**No**

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

☐	**Geographic Limitation**. A waiver of statewideness 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. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** 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. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

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 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) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

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 amount, frequency and duration 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/MR.

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 §431.51, 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 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:

The State Medicaid Agency completed the initial draft amendment in January 2014. The draft was posted for public comment on February 28, 2014. The proposed changes were submitted to a broad network of consumers, advocates, providers and Tribal Governments and the Medical Care Advisory Committee (MCAC) in February 2014. The entities have 30 days in which to submit comments or questions about the waiver amendment.

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.

7. Contact Person(s)

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

First Name:	Tonya
Last Name	Hales
Title:	Director, Bureau of Authorization and Community Based Services
Agency:	Utah Division of Medicaid and Health Financing
Address 1:	P. O. Box 143101
Address 2:	
City	Salt Lake City
State	Utah
Zip Code	84114-3101
Telephone:	801-538-9136
E-mail	thales@utah.gov
Fax Number	801-538-6412

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

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

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: _____ **Date:**

State Medicaid Director or Designee

First Name:	Michael
Last Name	Hales
Title:	Director
Agency:	Utah Division of Medicaid and Health Financing
Address 1:	P.O. Box 143101
Address 2:	
City	Salt Lake City
State	Utah
Zip Code	84114-3101
Telephone:	801-538-6965
E-mail	mthales@utah.gov
Fax Number	801-538-6099

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

State:	
Effective Date	

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)*:

⦿	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 (*select one;*:		
	⦿	The Medical Assistance Unit *(name of unit) (do not complete Item A-2*):	Utah Division of Medicaid and Health Care Financing, Bureau of Authorization and Community Based Services
	○	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit). This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (*Complete item A-2-a):*	
○	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. 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. (*Complete item A-2-b).*		

2. **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.

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:

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

○	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
⦿	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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 *(check each that applies)*:

☐	**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). *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**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). *Specify the nature of these entities and complete items A-5 and A-6*:
☑	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

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:

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 an administrative 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	☑	☐	☐	☐
Waiver enrollment managed against approved limits	☑	☐	☐	☐
Waiver expenditures managed against approved levels	☑	☐	☐	☐
Level of care evaluation	☑	☐	☐	☐
Review of Participant service plans	☑	☐	☐	☐
Prior authorization of waiver services	☑	☐	☐	☐
Utilization management	☑	☐	☐	☐
Qualified provider enrollment	☑	☐	☐	☐
Execution of Medicaid provider agreements	☑	☐	☐	☐
Establishment of a statewide rate methodology	☑	☐	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐	☐	☐
Quality assurance and quality improvement activities	☑	☐	☐	☐

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..

a.i For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:	**The SMA and OA collaborate in the development of waiver applications, waiver amendments, rules and other official documents relative to the administration and operation of the waiver.**		
Data Source ***Meeting minutes*** ***Correspondences (email, letters etc.)***	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and***	***Frequency of data aggregation and***	

	analysis *(check each that applies*	***analysis:*** *(check each that applies*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☑ *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure #2:	**The OA submits proposed rules and other documents, relating to the implementation of the waiver (including training curriculums and outreach materials), to the SMA for review and approval prior to implementation.**		
Data Source ***Document Approval Forms*** ***OA Documents***	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☑ *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure #3:	**The SMA approves maximum allowable rates (MARs) for covered waiver services.**		
Data Source ***Approval documentation*** ***Correspondence***	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☑ *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure #4:	**Prior to involuntary disenrollment from the waiver, the OA explores all reasonable alternatives and follows the Disenrollment Protocol. Final authority for involuntary disenrollment resides with the SMA.**		
Data Source ***Disenrollment documents*** ***Correspondence between the SMA and OA***	***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)*

State:	
Effective Date	

	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☑ *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure #5:	**Timely notice of appeal rights are provided to waiver applicants/participants who make one of the following claims: a) denied access to Medicaid waiver program, b) denied access to needed service while enrolled in the waiver or c) denied choice of provider if more than one qualified provider was available to render the service.**		
Data Source ***OA application denial records*** ***Participant records***	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify: OA: Continuously and*	

		ongoing *SMA: At a minimum every five years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: At a minimum every five years*	

Performance Measure #6:	**The OA provides the SMA a copy of all quality assurance activities reports which include an analysis of findings, remediation and quality improvement activities.**		
<u>Data Source</u> ***OA Reviews***	***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)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *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*	

	applies	applies	
	☐ State Medicaid Agency	☐ Weekly	
	☑ Operating Agency	☐ Monthly	
	☐ Sub-State Entity	☐ Quarterly	
	☐ Other: Specify:	☑ Annually	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

a.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 New Choices Waiver Program through numerous activities including the issuance of policies, rules and regulations relating to the waiver and the approval of all protocols, documents and trainings that affect any aspect of the New Choices Waiver operations. Approvals are accomplished through a formal document approval process. The SMA conducts an annual review of the New Choices Waiver Program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the OA and SMA review findings as well as other issues that develop during the review year. The sample size for the first year review will be sufficient to provide a confidence level equal to 95%, a response distribution of 50% , and a confidence interval equal to 5. For future years, the State will request a lower response distribution based on the statistical evidence of previous reviews.

The SMA is the entity responsible for official communication with CMS for all issues related to the New Choices Waiver.

b. Methods for Remediation/Fixing Individual Problems

b.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 the OA and the SMA that affect the health and welfare of individual participants are addressed immediately. Issues requiring immediate attention are addressed in a variety of ways. Depending on the circumstances of the individual case the interventions could include: contacting the OA, case management and/or direct care provider agencies requiring an immediate review and remediation of the issue, reporting the issue to APS and/or local law enforcement or the state's Medicaid Fraud Control Unit, the licensing authority or the survey/certification authority. To assure the issue has been addressed, entities assigned the responsibility of review and remediation are required to report back to the OA or SMA on the results of their interventions within designated time frames. 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 documented through the SMA final review report.

When the SMA determines that an issue is resolved, notification is provided and documentation is

maintained by the SMA.

b.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)*
	☑ *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☑ *Annually*
		☐ *Continuously and Ongoing*
		☐ *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 Administrative Authority that are currently non-operational.

○	**Yes** *(complete remainder of item)*
⦿	**No**

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

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 –	Maximum Age: No Maximum Age Limit
⦿	**Aged or Disabled, or Both** *(select one)*				
	○	**Aged or Disabled or Both – General** *(check each that applies)*			
	☑	Aged (age 65 and older)			☑
	☑	Disabled (Physical) (under age 65)	21	64	
	☑	Disabled (Other) (under age 65)	21	64	
	○	**Specific Recognized Subgroups** *(check each that applies)*			
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both** *(check each that applies)*				
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness (age 18 and older)			☐
	☐	Mental Illness (under age 18)			

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

Participation in the New Choices Waiver is limited to individuals who at the time of admission:
(a) are 18 years of age or older;
(b) are receiving nursing facility care and have been continuously receiving nursing facility care for a minimum of 90 days prior to admission; or
(c) are receiving assisted living facility care and have been continuously receiving assisted living facility care for a minimum of 180 days prior to admission; or
(d) are receiving Medicare or Medicaid reimbursed care in another type of Utah licensed medical institution that is not an institution for mental disease (IMD), on an extended stay of at least 30 days, and will discharge to a nursing facility for an extended stay of at least 60 days absent enrollment into the waiver program; or
(e) are receiving Medicaid reimbursed services through another of Utah's 1915(c) waivers and have been identified in need of immediate (or near immediate) nursing facility admission absent enrollment into this waiver program; or
(f) have previously been enrolled in the New Choices Waiver but were disenrolled from the waiver due

to receipt of a lump sum payment or other financial settlement that resulted in loss of Medicaid financial eligibility.

For individuals leaving acute care hospitals, specialty hospitals (non IMD), and Medicare skilled nursing facilities, participation is limited to those receiving a medical, non-psychiatric level of care.

Individuals who meet the intensive skilled level of care as provided in R414-502 are not eligible for participation in the New Choices Waiver.

Individuals who meet the level of care criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-ID) as provided in R414-502 are not eligible for participation in the New Choices Waiver.

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)*:

○	Not applicable – There is no maximum age limit
⦿	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):
	Disabled transition to Aged

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:

- ⦿ **No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.
- ○ **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. *Complete Items B-2-b and B-2-c*. The limit specified by the State is *(select one)*:
  - ○ _____ %, a level higher than 100% of the institutional average
  - ○ Other *(specify)*:
- ○ **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. *Complete Items B-2-b and B-2-c*.
- ○ **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. *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*.

  The cost limit specified by the State is *(select one)*:
  - ○ The following dollar amount: $ _____
    - The dollar amount *(select one)*:
      - ○ Is adjusted each year that the waiver is in effect by applying the following formula:
      - ○ 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.
  - ○ The following percentage that is less than 100% of the institutional average: _____ %
  - ○ Other – *Specify:*

State:	
Effective Date	

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*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	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:
☐	Other safeguard(s) *(specify)*:

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	1200
Year 2	1400
Year 3	1400
Year 4 (renewal only)	1700
Year 5 (renewal only)	1700

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)*:

⦿	The State does not limit the number of participants that it serves at any point in time during a waiver year.
○	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	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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)*:

⦿	**Not applicable**. The state does not reserve capacity.
○	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

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):*

⦿	The waiver is not subject to a phase-in or a phase-out schedule.
○	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 ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

⦿	Waiver capacity is allocated/managed on a statewide basis.
○	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:

No selection policies apply beyond the waiver targeting criteria described in Appendix B-1.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **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		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
Waiver Year:			
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

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

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

○	§1634 State
⦿	SSI Criteria State
○	209(b) State

a-2. Miller Trust State.

Indicate whether the State is a Miller Trust State.

○	Yes
⦿	No

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:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☐	Low income families with children as provided in §1931 of the Act		
☑	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
☑	Optional State supplement recipients		
☑	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	⦿	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL
☑	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	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)		
☐	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)		
☐	Medically needy in 209(b) States (42 CFR §435.330)		
☑	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		
☐	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*:		
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)
○	% of FBR, which is lower than 300% (42 CFR §435.236)
○	$ which is lower than 300%
☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
☐	Medically needy without spenddown 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*:

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)*:

⦿		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*):
	⦿	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	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.*
○		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 and *§*1634 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. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		

State:	
Effective Date	

○	The following dollar amount:	$	If this amount changes, this item will be revised.
⦿	The following formula is used to determine the needs allowance:		
	Up to $125 of any earned income and a general disregard of 100% of the FPL for one person; plus shelter cost deduction for mortgage & related costs (property taxes, insurance, etc.) or rent, not to exceed $300; plus the standard utility allowance Utah uses under Section 5(e) of the Food Stamp Act of 1977. Total shelter costs cannot exceed $300 plus the standard utility allowance. If other family members live with the waiver client, an additional amount in recognition of higher expenses that a waiver client may have to meet the extra costs of supporting the other family members will be considered, The additional amount 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 CFR435.726(c)(3).		
○	Other (specify):		

ii. <u>Allowance for the spouse only</u> (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	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.
○	The amount is determined using the following formula:		
○	Other (specify):		
○	Not applicable *(see instructions)*		

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:*	
○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 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. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			
○	Other (specify)			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	The following standard under 42 CFR §435.121			
○	Optional State supplement standard			
○	Medically needy income standard			
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The amount is determined using the following formula:			
○	Not applicable *(see instructions)*			
iii. <u>Allowance for the family</u> *(select one)*				

State:	
Effective Date	

○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ 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.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable *(see instructions)*

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. *Select one:*

○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

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 and §1634 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. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
⦿	The following formula is used to determine the needs allowance:			
	Up to $125 of any earned income plus an additional general disregard equal to the federal poverty limit for a household of one; plus a shelter cost deduction for actual mortgage & related costs (property taxes, insurance, etc.) or rent, not to exceed $300; & a utility cost deduction of $158 for households which have a heating or cooling expense, or $79 for a household which does not have a heating or cooling expense but has any other utility (water, phone, electricity, etc.).			
○	Other (specify):			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	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 the amount of the allowance:			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.

State:	
Effective Date	

	○	The amount is determined using the following formula:
⦿	Not applicable *(see instructions)*	

iii. <u>Allowance for the family</u> *(select one)*:	
○	AFDC need standard
⦿	Medically needy income standard
○	The following dollar amount: $ 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.
○	The amount is determined using the following formula:
○	Other *(specify)*:
○	Not applicable *(see instructions)*

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:*

○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
○	The State does not establish reasonable limits.
⦿	The State establishes the following reasonable limits *(specify)*:
	The State establishes the following reasonable limits: 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.

c-2. Regular Post-Eligibility: 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. <u>Allowance for the needs of the waiver participant</u> (*select one*):		
○	The following standard included under the State plan *(select one)*	
	○	The following standard under 42 CFR §435.121:

	○	Optional State supplement standard
	○	Medically needy income standard
	○	The special income level for institutionalized persons *(select one)*
		○ 300% of the SSI Federal Benefit Rate (FBR)
		○ % of the FBR, which is less than 300%
		○ $ which is less than 300% of the FBR
	○	% of the Federal poverty level
	○	Other standard included under the State Plan (specify):
○	The following dollar amount: $	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:	
○	Other (*specify):*	

ii. <u>Allowance for the spouse only</u> (*select one*):

○	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 the amount of the allowance:	
	○	The following standard under 42 CFR §435.121:
	○	Optional State supplement standard
	○	Medically needy income standard
	○	The following dollar amount: $ If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:
○	Not applicable *(see instructions)*	

iii. <u>Allowance for the family</u> *(select one)*

○	AFDC need standard	
○	Medically needy income standard	
○	The following dollar amount: $	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.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable *(see instructions)*

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. *Select one:*

○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

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. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
⦿	The following formula is used to determine the needs allowance:		
	Up to $125 of any earned income and a general disregard of 100% of the FPL for one person; plus shelter cost deduction for mortgage & related costs (property taxes, insurance, etc.) or rent, not to exceed $300; plus the standard utility allowance Utah uses under Section 5(e) of the Food Stamp Act of 1977. Total shelter costs cannot exceed $300 plus the standard utility allowance.		
○	Other (*specify*)**:**		
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:*			
○	Allowance is the same		
⦿	Allowance is different. Explanation of difference:		
	We added as additional amount to the allowance for the personal needs of a waiver participant without a community spouse to recognize the extra costs of supporting the other family members. The additional amount is the difference between the allowance for the family member defined in Section 1924(d)(1)(C) of the Social Security Act and the allowance for a family member defined in 42 CFR435.726(c)(3). We did not add that additional amount to the personal needs allowance of a waiver participant with a community spouse because the extra costs of supporting the other family members is recognized in section 1924(d)(1)(C).		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:			
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:*			
○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver*		

	participant, not applicable must be checked.
○	The State does not establish reasonable limits.
⦿	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

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 *(insert number):* 1	
ii.	**Frequency of services**. The State requires *(select one)*:	
	⦿	The provision of waiver services at least monthly
	○	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*):

○	Directly by the Medicaid agency (The SMA performs the initial level of care evaluation for entrance into the waiver program).
○	By the operating agency specified in Appendix A
⦿	By an entity under contract with the Medicaid agency. *Specify the entity*:
	Waiver Case Management agencies contracted with SMA to perform reevaluations of level of care.
○	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 the initial level of care evaluation are required to be Registered Nurses or Physicians licensed within the State of Utah.

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 State administrative rule R414-502 delineates the nursing facility level of care criteria that must be met to qualify for the Medicaid State Plan nursing facility benefit. In accordance with R414-502, it must be determined whether an applicant has mental or physical conditions that can only be cared for in a nursing facility, or equivalent alternative Medicaid health care delivery program, by documenting at least two of the following factors exist:

(a) due to diagnosed medical conditions, the applicant requires substantial physical assistance with activities of daily living above the level of verbal prompting supervision or setting up;

(b) The attending physician has determined the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through an alternative Medicaid health delivery program; or

(c) The medical condition and intensity of services indicate that care need of the applicant cannot be safely met in a less structured setting, or without the services and supports of an alternative Medicaid health care delivery program.

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)*:

○	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
⦿	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. 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.
	The InterRAI MINIMUM DATA SET- HOME CARE (MDS-HC) serves as the standard comprehensive assessment instrument for this waiver and includes all the data fields necessary to measure the individual's level of care as defined in the State's Medicaid nursing facility admission criteria. Persons responsible for collecting the needed information and for making level of care determinations are trained by staff of the SMA in the proper application of the MDS-HC instrument and the proper analysis of the MDS-HC data to perform level of care evaluations.

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:

Initial level of care evaluations:

1) For applicants who are currently receiving Medicaid reimbursed nursing facility services on an extended stay basis, and therefore have already had a level of care determination performed by the SMA under the nursing facility admission process, the prior determination will be considered as conditionally meeting the waiver level of care determination requirement. Within fourteen working days of having received a referral, the applicant selected case management provider will validate that the individual continues to meet level of care requirements during the completion of the initial waiver comprehensive needs assessment, using the standard instrument/tool described in Appendix B-6(e). In the event the conditional determination is not validated by the case

management provider, the individual will be advised through a written notice of agency action that the waiver eligibility criteria has not been met and offered an opportunity for a fair hearing.

2) For applicants who have not had level of care eligibility previously determined through the nursing facility admission process, a Department of Health RN will conduct a review of the standard instrument/tool, medical records and physician orders from the nursing facility to determine initial level of care. Within fourteen working days of having received a referral, the applicant selected case management provider will validate that the individual does meet level of care requirements during the completion of the initial waiver comprehensive needs assessment, using the standard instrument/tool described in Appendix B-6(e). In the event the conditional determination is not validated by the case management provider, the individual will be advised through a written notice of agency action that the waiver elgibility criteria has not been met and offered an opportunity for a fair hearing.

Level-of-care reevaluations:

The contracted case management provider will validate that the individual continues to meet level of care requirements during the completion of the annual (at a minimum) comprehensive reassessment of the participant's needs, using the standard instrument/tool described in Appendix B-6(e), (MDS-HC). In the event the reevaluation indicates the participant no longer meets nursing facility level of care, a Department of Health RN will be contacted by the case management provider to conduct a review of the standard instrument/tool to determine level of care. If a participant is determined to not meet the nursing facility admission criteria, the individual will be advised through a written notice of agency action that the waiver eligibility criteria has not been met and offered an opportunity for a fair hearing. The contracted case management provider will be required to maintain a separate up to date record listing all MDS-HC's and the dates they were completed. This record must be made available to the Bureau of Authorization and Community Based Services, Department of Health, upon request. Records will be reviewed as a component of the quality assurance monitoring completed by the SMA.

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)*:

○	Every three months
○	Every six months
○	Every twelve months
⦿	Other schedule (*specify*):
	The Participant's level of care is screened at the time a substantial change in the participant's health status occurs to determine whether the participant's resultant health status constitutes an ongoing nursing facility level of care, including at the conclusion of an inpatient stay in a medical institution. A full level of care reevaluation is conducted whenever indicated by a health status change screening and at a minimum annually (within the calendar month of the last level of care evaluation) from the last recorded level of care determination.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

⦿	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
○	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

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)*:

The level of care reevaluation and tracking process will be included as a standard requirement for all case management providers enrolled as waiver providers. Case management providers will be required to develop and maintain a tracking system to insure that reevaluations occur in a timely manner. Timeliness of reevaluations will periodically be reviewed by the Operating Agency and as part of the SMA Quality Assurance program.

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:

Records of level of care evaluations and reevaluations will be maintained in the participant's waiver case record maintained by the case management provider.

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.

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

a.i.a 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/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:	***The number and percentage of initial evaluations for level of care in a representative sample that are conducted for applicants who meet New Choices Waiver guidelines for enrollment.***		
Data Source	***Responsible Party for data***	***Frequency of data collection/generation:***	***Sampling Approach*** *(check each that*

New Choices Waiver Records	***collection/generation*** *(check each that applies)*	*(check each that applies)*	*applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	☑ *Operating Agency*	☐ *Monthly*	*Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*Representative Sample; Confidence Interval*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years*	
			X☐ Other: Describe OA: 100% SMA: Less than 100%, Confidence Interval = 5
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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify: OA: Annually SMA: At a minimum every five years.*	

Performance Measure #2:	***The number and percentage of new participants in a representative sample who are admitted to the New Choices Waiver that meet nursing facility LOC.***		
Data Source **LOC determination form**	***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)*

State:	
Effective Date	

MDS-HC			
	☑ *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	☑ *Operating Agency*	☐ *Monthly*	*Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			X☐ Other: Describe *OA: 100%* *SMA: Less than 100%, Confidence Interval = 5*
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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: At a minimum every five years.*	

a.i.b Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:	***The number and percentage of participants in a representative sample for whom a full level of care re-evaluation was conducted, at a minimum of annually (within the calendar month of the last level of care evaluation).***		
Data Source **LOC determination forms** **MDS-HC**	***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)*
	☑ State Medicaid Agency	*☐ Weekly*	*100% Review*
	☑ Operating Agency	*☐ Monthly*	*Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*Representative Sample; Confidence Interval*
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☑ Other: Specify: OA: Continuously and Ongoing *SMA: At a minimum every 5 years*	
			X☐ Other: Describe *OA: 100%* *SMA: Less than 100%, Confidence Interval = 5*
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*	
	☑ State Medicaid Agency	*☐ Weekly*	
	☑ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		☑ Other: Specify: *OA: Annually* *SMA: At a minimum every five years.*	

State:	
Effective Date	

Performance Measure #2:	***The number and percentage of participants in a representative sample for whom level of care was screened at the time a substantial change in health status occurred, including at the conclusion of an inpatient stay in a medical institution, to determine if the individual continued to meet nursing facility level of care.***		
Data Source **LOC determination forms** **MDS-HC** **Participant Records**	***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)*
	☑ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☑ Operating Agency	*☐ Monthly*	*☑ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☑ Representative Sample; Confidence Interval = 5*
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☑ Other: Specify: OA: Annually *SMA: At a minimum every 5 years*	
			☐ 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*	
	☑ State Medicaid Agency	*☐ Weekly*	
	☑ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		☑ Other: Specify: *OA: Annually* *SMA: At a minimum every five years.*	

Performance	***The number and percentage of participants in a representative sample***

State:	
Effective Date	

Measure #3:	***for which a full level of care re-evaluation was conducted when indicated by a health status change screening.***		
Data Source **LOC determination forms** **MDS-HC**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Annually* *SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: At a minimum every five years.*	

a.i.c ***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/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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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:	***The number and percentage of participants in a representative sample for whom an assessment for level of care was conducted by a qualified registered nurse or physician licensed in the state.***		
Data Source **MDS-HC**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *At a minimum every five years.*	

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Performance Measure #2:	***The number and percentage of participants, in a representative sample for whom the Level of Care Determination Form accurately documents the LOC criteria based on the MDS-HC assessment***		
Data Source **LOC determination forms** **MDS-HC** **Participant Records**	***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)*
	☑ State Medicaid Agency	*☐ Weekly*	*☐100% Review*
	☐ Operating Agency	*☐ Monthly*	*☑ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☑ Representative Sample; Confidence Interval*
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☑ Other: Specify: SMA: At a minimum every five years.	
			☐ 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*	
	☑ State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		☑ Other: Specify: SMA: At a minimum every five years.	

Performance Measure #3:	***The number and percentage of participants in a representative sample for whom the Form 927, "Home and Community-Based Waiver Referral Form" documented the effective date of the applicant's Medicaid***

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	eligibility determination and the effective date of the applicant's level of care eligibility determination.		
Data Source **Participant records** **Form 927**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: At a minimum every 5 years.*	

a.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.

All individuals who request New Choices Waiver services and who meet minimum requirements are evaluated by an R.N. using the Minimum Data Set for Home Care (MDS-

HC) tool to determine if the applicant meets nursing facility level of care.
For Initial Level of Care Determinations:
The general requirements of this waiver provide upfront fail-safe mechanisms for assuring level of care determinations are completed by qualified individuals for all new entrants into the waiver.
The New Choice Waiver (NCW) requires applicants to be found eligible for nursing facility level of care during their 90-day minimum stay in a nursing facility. For each NCW applicant, the level of care determination is made by the Utah Department of Health registered nurses who perform this task for all Medicaid nursing facility admissions (this is the state's gold standard level of care evaluation process). Prior to initiating admission to the NCW, the OA must have a copy of the level of care determination conducted by the Utah Department of Health registered nurses. This assures that 100% of the cases meet the requirement "LOC was conducted by a qualified registered nurse or physician licensed in the state." In addition, to assure that the level of care has not changed from the time the determination was made by the Department of Health registered nurses, the New Choices Waiver case management registered nurses complete a MDS-HC and assure the applicant meets level of care prior to enrollment in the waiver. This documentation is required to be submitted to the OA by the case management agency prior to the applicant's enrollment in the program. Applicants are not enrolled into the program without this documentation. In this way, the OA assures level-of-care is met on a continuous and ongoing basis.

For Level of Care Re-evaluation Determinations:
Annually at a minimum, case management agencies are required to submit copies of level of care re-determinations and new care plans. New care plans will not be authorized without receiving the written evidence that an annual level of care re-evaluation has been completed and the participant continues to meet nursing facility level of care. The written evidence must be signed by the registered nurse or physician.

The OA tracks the number of level-of care determinations and redeterminations completed and by whom the determinations were made. The OA then reports the information to the SMA on an annual basis. The SMA will review the annual report and determine if the performance measure has been met. In the event the SMA determines the performance measure has not been met the SMA will require the OA develop and implement an approved corrective action or quality improvement initiative.
The SMA conducts an annual review of the New Choices Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the OA and SMA review findings as well as other issues that develop during the review year. The sample size for the first year review will be sufficient to provide a confidence level equal to 95%, a response distribution of 50% , and a confidence interval equal to 5. For future years, the State will request a lower response distribution based on the statistical evidence of previous reviews.

b. Methods for Remediation/Fixing Individual Problems

b.i *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem*

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correction. In addition, provide information on the methods used by the State to document these items.

Individual issues identified by the SMA and the OA, that affect the health and welfare of individual participants are addressed immediately. Issues that are less immediate are corrected within designated time frames and are documented through the SMA final review report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained by the SMA.

b.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)*
	☑ *State Medicaid Agency*	☐ *Weekly*
	☑ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		☑ *Other: Specify:* *OA: Annually.* *SMA: At a minimum every five 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 Level of Care that are currently non-operational.

○	**Yes** *(complete remainder of item)*
⦿	**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).

1. The State Medicaid Agency's LTC Health Program Specialist who is responsible for assisting the waiver applicant in completing the eligibility determination and enrollment process will provide information to the individual about the types of services available through the waiver and through the Medicaid nursing facility program as part of a pre-enrollment education and screening process.

2. When an individual is determined to be likely to require the nursing facility level of care and the LTC Health Program Representative determines that the individual can adequately be served in the community, the person or the person's legal representative is:

    a. Informed of any feasible alternatives under the waiver; and

    b. Given the choice of either institutional or home and community-based services.

3. The individual is informed that the State Medicaid Agency provides an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to nursing facility institutional care.

4. A standard form will be signed by the participant to indicate the provision of choice.

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 forms will be maintained in the participant's waiver case record maintained by the case management provider and also in the records maintained by the LTC Health Program Specialists.

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):

Information regarding access to Medicaid Translation Services is included in the Medicaid information booklet, "Exploring Medicaid," distributed to all Utah Medicaid recipients. Eligible individual may access translation services by calling the Medicaid Helpline.
For the full text of the "Exploring Medicaid" brochure, go to http://hlunix.ex.state.ut.us/medicaid/ and select the "Exploring Medicaid" hyperlink.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

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	☑	
Homemaker	☑	
Home Health Aide	☐	
Personal Care	☐	
Adult Day Health	☑	Adult Day Care
Habilitation	☑	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	☑	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
⦿	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Adult Residential Services a) b) Assisted living facilities

	b) Licensed community residential care facilities c) Certified community residential care facilities
b.	Attendant Care Services
c.	Caregiver Training
d.	Chore Services
e.	Environmental Accessibility Adaptations a) Home Modifications b) Vehicle Modifications
f.	Home Delivered Meals
g.	Community Transition Services
h.	Medication Assistance Services a) Medication Reminder System b) Medication Set-up
i.	Personal Emergency Response System a) Purchase, Rental and Repair b) Installation, Testing and Removal c) Response Center Service Fee
j.	Assistive Technology Devices
k.	Specialized Behavioral Health Services
Extended State Plan Services *(select one)*	
○	Not applicable
⦿	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	Supportive Maintenance (Home Health Aide) Services
Supports for Participant Direction *(check each that applies))*	
⦿	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.
☐	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.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☑	Consumer Preparation Services
Financial Management Services	☑	

Other Supports for Participant Direction *(list each support by service title)*:	
a.	
b.	
c.	

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants *(check each that applies)*:

☑	As a waiver service defined in Appendix C-3 (*do not complete C-1-c)*
☐	As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*
☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c*.
☐	As an administrative activity. *Complete item C-1-c. NOTE: Pursuant to CMS-2237-IFC* this selection is no longer available for 1915(c) waivers.
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

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

Any enrolled Medicaid waiver case management provider, meeting the qualifications described in Appendix C-3 of this application, may conduct case management functions on behalf of waiver participants.

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)*:

⦿	**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):
	The Utah Code, Section 26-21-9.5, requires that a Bureau of Criminal Identification screening, referred to as BCI, and a child or disabled or elderly adult licensing information system screening be conducted on each person who provides direct care to a patient for the following covered health care facilities: (1) Home health care agencies; (2) Hospice agencies; (3) Nursing Care facilities; (4) Assisted Living facilities; (5) Small Health Care facilities; and (6) End Stage Renal Disease Facilities. The Utah Code, Section 26-21-9.5, does not require self administered service providers to have a BCI screening and therefore, hiring is not contingent upon an investigation. However, under the law, a participant has the option of requesting that a self administered service provider have a BCI screening completed and the participant will be provided with a copy of the results. The law states that the participant receiving self-directed services can ask for the screening to be completed prior to or within 10 days of initial hiring
○	**No**. Criminal history and/or background investigations are not required.

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)*:

○	**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):
⦿	**No**. The State does not conduct abuse registry screening.

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

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*

⦿	**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). *Complete Items C-2-c.i –c.iii.*

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
Licensed Community Residential Care Facility	Adult Residential Services	No Limit
Assisted Living Facilities	Adult Residential Services	No Limit

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.

Basic Utah licensing requirements for health care facilities regulated by the Utah Department of Health mandate that non-institutional facilities that serve four or more individuals provide single occupancy accommodations to their residents, except in the case where two individuals choose to share the living accommodation. Required features include space and equipment for food preparation and private and semi-private toilet facilities. In addition, provision is made for shared dining, internal group and individual activities, and opportunities to participate in community activities. Similar standards are required for residential treatment facilities licensed by the Department of Human Services Office of Licensing.

Beyond these basic licensing provisions for privacy and community integration, current State policy does not prescribe an arbitrary maximum size to qualify for Medicaid reimbursement as a non-institutional residential living setting or attempt to differentiate the quality of a waiver participant's residential experience solely on the basis of size, number of occupants, or other physical plant design factors. Instead, the SMA encourages and fosters the development of a vast array of community based settings that are responsive to the needs and desires of the full spectrum of Medicaid participants eligible for participation in the New Choices Waiver. The State's approach is to promote home and community based character by providing a wide variety of options from which to choose, affording participants ongoing opportunities to transition across residential options based upon the participant's needs and individual preferences. With regard to larger residential settings, enrolled providers will to the greatest extent possible provide consumers with choices about their individual schedules and the living arrangements will be such that consumers have private living space, are at liberty to decide how they want to structure their schedules and activities and have access to their own amenities.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type Licensed Community Residential Facilities and Assisted Living Facilities	Facility Type	Facility Type	Facility Type
Admission policies	☑	☐	☐	☐
Physical environment	☑	☐	☐	☐
Sanitation	☑	☐	☐	☐
Safety	☑	☐	☐	☐
Staff : resident ratios	☑	☐	☐	☐
Staff training and qualifications	☑	☐	☐	☐
Staff supervision	☑	☐	☐	☐
Resident rights	☑	☐	☐	☐

Medication administration	☑	☐	☐	☐
Use of restrictive interventions	☑	☐	☐	☐
Incident reporting	☑	☐	☐	☐
Provision of or arrangement for necessary health services	☑	☐	☐	☐

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:

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:*

⦿	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**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 ***extraordinary care*** 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. *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*.

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*:

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
○	The State makes payment to relatives/legal guardians under ***specific circumstances*** 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. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
○	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-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
⦿	Other policy. *Specify*:
	The State will permit the provision of waiver services furnished by relatives who are not legally responsible individuals whenever the relative is qualified to provide services as specified in Appendix C-3.

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:

The SMA will enter into a provider agreement with all willing providers who meet licensure, certification and/or other qualifications. The SMA will employ various strategies to enlist providers as New Choices Waiver service providers including: Printing periodic articles in the Medicaid Information Bulletin, meeting with various provider groups including the Utah Assisted Living Association, the Utah Health Care Association and the Utah Association of Community Services Providers, and sending solicitation letters out to providers that are currently enrolled to provide services in Utah's other 1915(c) Home and Community Based Waiver Programs.

Interested providers will be required to complete a Medicaid provider agreement and all required documentation verifying provider qualification to the SMA. The application and documentation will then be reviewed by SMA staff for completeness. Upon approval of the application, it will be sent to the DMHF, Bureau of Medicaid Operations for processing. Upon assignment of a Medicaid Provider Number, the SMA will send the provider confirmation of their provider number, billing instructions, and a waiver provider manual. Provider training will be provided based upon the various provider types.

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**

a.i.a ***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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 licensed health care facilities, in a representative sample that maintain substantial compliance with State and Federal Regulations.***		
Data Source	***Responsible Party for data***	***Frequency of data collection/generation:***	***Sampling Approach*** *(check each that*

Bureau of Licensing Records	***collection/generation*** *(check each that applies)*	*(check each that applies)*	*applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other: Specify:* DOH Bureau of Licensing	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify: At a minimum every 2 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify: At a minimum every 2 years*	

Performance Measure #2:	***The number and percentage of provider files, in a representative sample that contain current business licenses and/or professional licenses.***		
<u>Data Source</u> **OA Files** **Provider 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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	☑ *Operating Agency*	☐ *Monthly*	*Less than 100% Review*

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	☐ *Sub-State Entity*	☐ *Quarterly*	*Representative Sample; Confidence Interval*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			X☐ Other: Describe *OA: 100%* *SMA: Less than 100%, Confidence Interval = 5*
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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: at a minimum every five years.*	

a.i.b Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:	***The number and percentage of Independent Living Facilities in a representative sample that initially meet and annually maintain NCW certification standards.***		
Data Source **OA 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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	☑ *Operating Agency*	☐ *Monthly*	*Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*Representative Sample; Confidence Interval*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			X☐ Other: Describe *OA: 100%* *SMA: Less than 100%, Confidence Interval = 5*
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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: at a minimum every five years.*	

State:	
Effective Date	

a.i.c 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.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:	***The number and percentage of case management agencies in a representative sample that receive annual New Choices Waiver training.***		
Data Source **OA 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)*
	☑ State Medicaid Agency	*☐ Weekly*	*100% Review*
	☑ Operating Agency	*☐ Monthly*	*Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*Representative Sample; Confidence Interval*
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☑ Other: Specify: *OA: Annually* *SMA: At a minimum every 5 years*	
			X☐ Other: Describe *OA: 100%* *SMA: Less than 100%, Confidence Interval = 5*
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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	applies	*applies*	
	☑ State Medicaid Agency	*☐ Weekly*	
	☑ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		☑ Other: Specify: *OA: Annually* *SMA: at a minimum every five years.*	

Performance Measure #2:	***The number and percentage of adult residential providers in a representative sample that receive annual New Choices Waiver training.***		
Data Source **OA 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)*
	☑ State Medicaid Agency	*☐ Weekly*	*100% Review*
	☑ Operating Agency	*☐ Monthly*	*Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*Representative Sample; Confidence Interval*
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☑ Other: Specify: *OA: Annually* *SMA: At a minimum every 5 years*	
			X☐ Other: Describe *OA: 100%* *SMA: Less than 100%, Confidence Interval = 5*
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*	
	☑ State Medicaid	*☐ Weekly*	

State:	
Effective Date	

	Agency		
	☑ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		☑ Other: Specify: *OA: Annually* *SMA: at a minimum every five years.*	

Performance Measure #3:	***The number and percentage of Assisted Living Facilities in a representative sample that provided the annual training required by the Department of Health.***		
<u>Data Source</u> **OA 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)*
	☑ State Medicaid Agency	*☐ Weekly*	*☐100% Review*
	☐ Operating Agency	*☐ Monthly*	*☑ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☑ Representative Sample; Confidence Interval = 5*
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☑ Other: Specify: *SMA: At a minimum every 5 years*	
			☐ 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*	
	☑ State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and	

		Ongoing	
		☑ *Other: Specify: SMA: at a minimum every five years.*	

a.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 conducts an annual review of the New Choices Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the OA and SMA review findings as well as other issues that develop during the review year. The sample size for the first year review will be sufficient to provide a confidence level equal to 95%, a response distribution of 50% , and a confidence interval equal to 5. For future years, the State will request a lower response distribution based on the statistical evidence of previous reviews.

b. Methods for Remediation/Fixing Individual Problems

b.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 the SMA and the OA, that affect the health and welfare of individual participants are addressed immediately. Issues that are less immediate are corrected within designated time frames and are documented through the SMA final review report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained by the SMA.

b.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)*
	☑ *State Medicaid Agency*	☐ *Weekly*
	☑ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*

	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		☐ *Other: Specify : OA: Annually* *SMA: At a minimum every 5 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 Qualified Providers that are currently non-operational.

○	**Yes** *(complete remainder of item)*
⦿	**No**

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

State:	
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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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	
Service Title:	**Case Management**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Services that assist participants in gaining access to needed waiver service and other Medicaid State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source. Case Management consists of the following activities:

a) Complete the initial comprehensive assessment and periodic reassessments to determine the services and supports required by the participant to prevent unnecessary institutionalization ;
b) Perform reevaluations of participants' level of care;
c) Complete the initial comprehensive care plan and periodic updates to address the participants identified needs;
d) Research the availability of non-Medicaid resources needed by an individual to address needs identified through the comprehensive assessment process and assist the individual in gaining access to these resources;
e) Assist the individual to gain access to available Medicaid State Plan services necessary to address identified needs;
f) Assist the individual to select from available choices, an array of waiver services to address the identified needs and assist the individual to select from the available choice of providers to deliver each of the waiver services;
g) Assist the individual to request a fair hearing if choice of waiver services or providers is denied;
h) Monitor to assure the provision and quality of services identified in the individual's care plan;
i) Support the individual/legal representative/family to independently obtain access to services when other funding sources are available;
j) Monitoring the individual's health and safety status;
k) Coordinate across Medicaid programs to achieve a holistic approach to care;
l) Provide case management and transition planning services up to 180 days immediately prior to the date an individual transitions from a nursing facility to the waiver program;
m) Provide discharge planning services to an individual disenrolling from the waiver;
n) Perform internal quality assurance activities, addressing all performance measures.

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

In order to facilitate transition, case management services may be furnished up to 180 days prior to transition and providers may bill for this service once the participant enters into the waiver program.

12 units per month or less is the expected typical case management utilization pattern. Plans that include utilization of 16 units or greater will require submission of additional documentation to justify the need for additional services. In cases where additional information does not justify the need for additional services, upon obtaining consent from the applicant, their information will be shared with other available case management agencies to determine if another agency is able to provide services within the 16 unit limit.

Provider entities having the capacity to perform multiple case management functions must assure that the separation between the functions of the entity are clearly separated and their respective responsibilities well defined.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Area Agencies on Aging
				Division of Services for People with Disabilities
				Independent Living Centers
				Certified Case Management Agencies

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Area Agencies on Aging	AAA employees with RN and SSW licensure		(a) Recognized Area Agency on Aging entity within the State (b) Medicaid provider enrolled to provide case management.
Division Services for People with Disabilities	DSPD employees with RN and SSW licensure		(a) Recognized Division of Service for People with Disabilities entity (b) Medicaid provider enrolled to provide case management.
Prepaid Inpatient Health Plans	PIHP employees with RN and SSW licensure		(a) Recognized Division of Service for People with Disabilities entity (b) Medicaid provider enrolled to provide case management. (c) Services provided under this waiver are paid to PIHPs on a fee-for-service basis only.
Independent Living Centers	ILC employees with RN and SSW licensure		(a) Independent Living Centers Recognized through the State Office of Rehabilitation (b) Medicaid provider enrolled to provide case management.
Accredited Case Management Agencies	Case Management Agency employees with RN and SSW licensure		(a) Case Management Agency accredited by DMHF approved organization. (b) Medicaid provider enrolled to provide case management.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Case Management Providers	Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services	Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	**Homemaker**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Services consisting of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
This service cannot be provided to consumers receiving Adult Residential Services or any other waiver service in which the tasks performed are duplicative of the homemaker services.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
		Self-administered services providers		Homemaker Agency and Home Health Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency Based - Homemaker	Current Business License		(a) Medicaid provider enrolled to provide Homemaker services (b) Demonstrated ability to perform the tasks ordered by the case management agency

State:	
Effective Date	

Self-administered services – Homemaker			(a) Medicaid provider enrolled to provide Homemaker services (b) Demonstrated ability to perform the tasks ordered by the case management agency

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Homemaker Services	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	**Adult Day Care (Adult Day Health)**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Services generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the care plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Transportation between the participant's place of residence and the adult day care site is not provided as a component of adult day care services and the cost of this transportation is not included in the rate paid to adult day care providers.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Licensed Adult Day Care Facilities
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

State:	
Effective Date	

Licensed Adult Day Care Facilities	Adult Day Care Center: UAC R501-13-1-13 or R432-150-6 or R 432-270-29		Medicaid Provider enrolled to provide adult day care services.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Day Care	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification

Service Title:	**Habilitation Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Habilitation Services are services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Specific services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion).

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

The following are specifically excluded from payment for habilitation services:

a. vocational services,
b. prevocational services,
c. supported employment services, and
d. room and board.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Habilitation Providers

State:	
Effective Date	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Habilitation Services	R432-700 , Current Business License		Demonstrated ability to performs the tasks ordered on behalf of the waiver participant Medicaid Providers enrolled to provide habilitation services.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Habilitation Providers	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification

Service Title:	**Respite Care Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Care provided to give relief to, or during the absence of, the normal care giver. Respite care may include hourly, daily and overnight support and may be provided in the individual's place of residence, a facility approved by the State which is not a private residence, or in the private residence of the respite care provider.

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

Payments for respite services are not made for room and board except when provided as a part of respite care in a setting, approved by the State that is not the individual's private residence. In the case of respite care services that include room and board are rendered out of the consumer's private residence in a setting approved by the State, this service will be billed under a specific "Respite Care-Out of the home/Room and Board included" billing code.

All instances in which respite care services are delivered for a period of six hours or more within a day shall be billed using a daily rate rather than hourly rates for this service.

Each Residential Respite Care episode is limited to a period of 13 consecutive days or less not counting the day of discharge. The number of Residential Respite Care episodes may not exceed three in any calendar year.

Field Code Changed

Provider Specifications

Provider Category(s)	☑	Individual. List types:	☑	Agency. List the types of agencies:
		Self-administered Services		Home Health Agencies

State:	
Effective Date	

(check one or both):	Employees	
		Licensed Health Care Facilities
		Licensed Residential Treatment Facilities

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	R432-700		Demonstrated ability to performs the tasks ordered on behalf of the waiver participant All providers: Medicaid provider enrolled to provide respite services.
Adult Day Care	R501-13-1		
Nursing Facilities	R432-150		
Assisted Living Facilities	R432-270		
Residential Treatment Facility	R501-19-13		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Respite Care Services	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification

Service Title:	**Adult Residential Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
⦿	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

State:	
Effective Date	

Personal care and supportive services (homemaker, chore, attendant services, meal preparation), including companion services, medication oversight (to the extent permitted under State law), including 24 hour on-site response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety and security in conjunction with residing in a homelike, non-institutional setting. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). Services provided by third parties must be coordinated with the residential services provider.

Service and support include 24 hour on-site response capability or other alternative emergency response arrangements determined appropriate to meet scheduled or predictable participant needs and to provide supervision, safety and security in conjunction with residing in a homelike, non-institutional setting.

Nursing and skilled therapy services are incidental, rather than integral to the provision of adult residential services.

Types of Adult Residential Services Providers:

a) Assisted living facilities
b) Licensed community residential care facilities
c) Certified community residential care facilities*

* Certified community residential care facilities are those in which 3 or fewer individuals reside.

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

Separate payment is not made for homemaker services, chore services, or companion services furnished to a participant receiving adult residential services, since these services are integral to and inherent in the provision of adult residential services.

Payment is not made for 24-hour skilled care or supervision. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for adult residential services is described in Appendix I.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐ Individual. List types:	☑ Agency. List the types of agencies:
		Assisted Living Facilities, Licensed community residential care facilities, Certified community residential care facilities.

Specify whether the service may be provided by *(check each that applies):*	☐ Legally Responsible Person	☐ Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Community Residential Care Facilities **Licensed Community**	Current Business License R432-270 R432-200	SMA or OA Certification	All Providers: Medicaid provider enrolled to provide adult residential services

State:	
Effective Date	

Residential Care Facilities	R432-300 or R501-19		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Residential Services	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	**Attendant Care Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
⦿	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Attendant care services are those that reinforce an individual's strengths, while substituting or compensating for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant services incorporate and respond to the participant's preferences and priorities.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
This service cannot be provided to participants receiving any other waiver service in which the tasks performed are duplicative of the attendant care services.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
		Individual employees hired under the self-administered services method		Home Health Agency Personal Care Services Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

State:	
Effective Date	

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Attendant Care Services	Current business license		All providers: Medicaid providers enrolled to provide attendant care services

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Attendant Care Services	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	**Caregiver Training**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship, or support to a person served on the waiver. Individuals who are employed to support the participant may not receive this service. Training includes instruction about treatment regimens and other services included in the care plan, use of equipment specified in the care plan, and includes updates as necessary to safely maintain the participant at home. All training the individuals who provide unpaid support to the participant must be included in the participant's care plan. The service covers the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the care plan.

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

No limits

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Formal training suppliers; home health agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
As authorized by State law for specific training category	R156 or R432 as applicable (providers of training in categories requiring license under State law) **Or** Current business license (formal training suppliers)		(a) Demonstrated ability to perform the tasks ordered by the case management agency. (b) Medicaid provider enrolled to provide caregiver training

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All Caregiver Training Suppliers	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Title:	**Chore Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
⦿	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, carpet cleaning, pest eradication, windows and walls, tacking down

loose rugs and tiles, moving heavy items of furniture in order to provide safe access or egress.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other caregiver, landlord, community/volunteer agency, or third party payer is capable or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service. Additionally this service in not available concurrent with any other waiver service in which the tasks performed are duplicative of chore services.

Provider Specifications

Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
		Individual employees hired under the self-administered services method		Chore service providers

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Chore Services	Current Business License		(a) Medicaid provider enrolled to provide chore services (b) demonstrated ability to perform the tasks ordered by case management provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Chore Services	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Title:	**Environmental Accessibility Adaptations** a) Home Modifications b) Vehicle Modifications

State:	
Effective Date	

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Equipment and/or physical adaptations to the individual's residence or vehicle which are necessary to assure the health, welfare and safety of the individual or which enable the individual to function with greater independence in the home and in the community, and without which, the individual would require institutionalization. The equipment/adaptations are identified in the individual's care plan and the model and type of equipment are specified by a qualified individual. The adaptations may include purchase, installation, and repairs. Other adaptation and repairs may be approved on a case by case basis as technology changes or as an individual's physical or environmental needs change. All services shall be provided in accordance with applicable State or local building codes and may include the following:

- Home

  Authorized equipment/adaptations such as:

  a. Ramps
  b. Grab bars
  c. Widening of doorways/hallways
  d. Modifications of bathroom/kitchen facilities
  e. Modification of electric and plumbing systems which are necessary to accommodate the medical equipment, care and supplies that are necessary for the welfare of the individual.

- Vehicle

  Authorized vehicle adaptations such as:

  1. lifts
  2. door modifications
  3. steering/braking/accelerating/shifting modifications
  4. seating modifications
  5. safety/security modifications

The following are specifically excluded:

a. Adaptations or improvements to the home or vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
b. Adaptations that add to the total square footage of the home;
c. Purchase or lease of a vehicle; and
d. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

Service Limit: The maximum allowable cost per environmental accessibility adaptation is $2,000.00. At the point a waiver participant reaches the service limit, the care coordination team will conduct an evaluation to determine how the individual's health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.

Provider Specifications				
Provider	☐	Individual. List types:	☑	Agency. List the types of agencies:

State:	
Effective Date	

Category(s) *(check one or both)*:		Environmental adaptations suppliers

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Environmental Adaptations Supplier	Current business license **and** Contractor's license when applicable		All providers: Demonstrated ability to perform the tasks ordered by the case management agency.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Environmental Adaptations Supplier	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Title:	**Home Delivered Meals**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Home Delivered Supplemental Meal provides a nutritionally sound and satisfying meal to individuals who are unable to prepare their own meals and who do not have a responsible party or volunteer caregiver available to prepare their meals for them.

Elements of Home Delivered Supplemental Meal Category: The Home Delivered Supplemental Meal category includes a prepared meal component and a nutritional supplement component. Either component constitutes a supplemental meal when provided in an amount that meets the nutritional needs of the individual. Each supplemental meal provided shall provide a minimum of 33 1/3 percent of the daily Recommended Dietary

Allowances (RDA) and Dietary Reference Intake (DRI) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, Institute of Medicine and Mathematica Policy Research, Incorporated.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Meals provided as part of this service shall not constitute a "full nutritional regimen" (3 meals per day).

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Restaurants, Health care facilities, Local Public agencies

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Delivered Meals	Current business license		Compliance with UAC R70-530 All programs: Medicaid providers enrolled to provide home delivered meals

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Delivered Meals	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Title:	**Community Transition Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
⦿	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Provision of essential household items and services needed to establish basic living arrangements in a

community setting that enable the individual to establish and maintain health and safety. Essential household items include basic furnishings and kitchen and bathroom equipment and goods. This service also includes moving expenses, one-time non-refundable fees to establish utility services and other services essential to the operation of the residence, and services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.

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

Reimbursement for the cost of rent or food is not a covered expense under this service. Reimbursable items are limited to only those household items that are essential. Reimbursement for the cost of refundable fees or deposits is not a covered expense under this service.

The maximum allowable cost for this service is $1,000.00. At the point a waiver participant reaches the allowable cost limit, the operating agency will conduct an evaluation to determine authorization of any additional service.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Suppliers of household furnishings, equipment and supplies.

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Institutional Transition Suppliers	Current business license if applicable		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Institutional Transition Suppliers	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Title:	**Medication Administration Assistance Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	

⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

- Medication Reminder System (Not Face-To-Face)
  Medication Reminder System provides a medication reminder by a third party entity or individual that is not the clinician responsible for prescribing and/or clinically managing the individual, not the entity responsible for the administration of medication, and not the entity responsible for the provision of nursing or personal care, attendant care, or companion care services. Services involve non face-to-face medication reminder techniques (e.g. phone calls, telecommunication devices, medication dispenser devices with electronic alarms which alert the individual and a central response center staffed with qualified individuals, etc.)

- Medication Set-Up and Administration
  Services of an individual authorized by State law to set-up medications in containers that facilitate safe and effective self-administration when individual dose bubbling packaging by a pharmacy is not available and assistance with self-administration is not covered as an element of another waiver service. Nurses may also assist individuals in the administration of medications as part of a medication maintenance regimen.

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

This service is not available to individuals eligible to receive the service through the Medicaid State Plan or other funding source.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐ Individual. List types:	☑ Agency. List the types of agencies:
		Medication reminder equipment suppliers, Home health agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Medication Administration Assistance	UAC R156-31b (medication set-up) Current business license as applicable (reminder devices)		Medicaid provider enrolled to provide medication administration assistance.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Medication Administration Assistance	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Title:	**Personal Emergency Response System**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

An electronic device that enables an individual to secure help in an emergency through a connection to a signal response center that is staffed by trained professionals on a 24 hour per day, seven days a week basis.

- 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 System (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 System (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:

No Limits

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Personal Emergency Response System supplier; Home Health Agency; Other response centers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Emergency	Current business		

State:	
Effective Date	

Response System Supplier Personal Emergency Response System Installer Personal Emergency Response Center	license, **and** Current business license, **and** Current business license, **and**		Equipment suppliers: FCC registration of equipment placed in the individual's home. Installers: Demonstrated ability to properly install and test specific equipment being handled. Response Centers: 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
Emergency Response System	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Title:	**Specialized Medical Equipment and Supplies**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service covers items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan.

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

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items

shall meet applicable standards of manufacture, design and installation. Coverage includes the costs of maintenance and upkeep of equipment, training the participant or caregivers in the operation and/or maintenance of the equipment or the use of a supply, and the performance of assessments to identify the type of equipment needed by the participant.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Medical equipment and supply suppliers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Medical equipment and supply suppliers	**Current business license if applicable**		Medicaid provider enrolled to provide medical equipment and supplies.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Medical equipment and supply suppliers	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Title:	**Transportation - Non-Medical**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, and does not replace them. Transportation services under the waiver are offered in accordance with the participant's care

plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Non-Medical transportation is not available for the provision of transportation to medical appointments.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Public transit agencies, taxi companies, private transportation companies.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Non-Medical Transportation	Licensed public transportation carrier or Individual driver's license		All providers: (a) Registered and insured vehicle: UCA 53-3-202, UCA 41-12s-301 to 412 (b) Medicaid provider enrolled to provide non-medical transportation services.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Non-Medical Transportation Providers	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Title:	**Personal Budget Assistance**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

State:	
Effective Date	

Personal budget assistance provides assistance with financial matters, fiscal training, supervision of financial resources, savings, retirement, earnings and funds monitoring, monthly check writing, bank reconciliation, budget management, tax and fiscal record keeping and filing, and fiscal interaction on behalf of the individual.

The purpose of this service is to offer opportunities for waiver participants to increase their ability to provide for their own basic needs, increase their ability to cope with day to day living, maintain more stability in their lives and maintain the greatest degree of independence possible, by providing timely financial management assistance to waiver participants in the least restrictive setting, for those individuals who have no close family or friends willing to take on the task of assisting them with their finances.

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

The Personal Budget Assistance provider must assist the waiver participant in reviewing their finances/budget at least monthly, must maintain documentation of this review and must submit the budget review documentation to the Case Management Agency for review on a monthly basis. The services provided in this service will not duplicate FMS services (i.e., tax and fiscal filing).

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Personal Budget Assistance Providers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Budget Assistance	Current Business License		Medicaid provider enrolled to provide personal budget assistance. Demonstrated ability to perform task.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Budget Assistance	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Title:	**Assistive Technology Devices**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

This service under the waiver differs in nature, scope, supervision arrangements, or provider from services in the State plan. Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes--

(A)The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

(B) Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

(C) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

(D) Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the care plan;

(E) Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

(F) Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

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

Service Limit: The maximum allowable cost per assistive technology device is $2,000.00. At the point a waiver participant reaches the service limit, the care coordination team will conduct an evaluation to determine how the individual's health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.

Therapies that are not directly related to instructing the participant on the use or selection of an assistive device are not covered under this service.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Assistive technology device supplier

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Assistive Technology Device Supplier	Current Business License		Medicaid provider enrolled to provide assistive technology device supplier

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Assistive Technology Device Supplier	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

	Division of Medicaid and Health Financing	

Service Title:	**Supportive Maintenance (Home Health Aide) Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Services defined in 42 CFR 440.70 that are provided when home health aide services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from home health aide services furnished under the State plan. Services are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Supportive maintenance services will only be ordered after full utilization of available State Plan home health services by the participant.	

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Home Health Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Supportive Maintenance Services	Home Health Agency: UAC R432-700	Certified by the LTCB as an authorized provider of services and supports.	Under State contract with LTCB as an authorized provider of services and supports.

State:	
Effective Date	

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Supportive Maintenance Services	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Title:	**Consumer Preparation Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Services that assist the participant (or the participant's family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the care plan. This service does not duplicate other waiver services, including case management.

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

This service is limited to participants who direct some or all of their waiver services.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Independent Living Centers

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

State:	
Effective Date	

Consumer Preparation Services	Have entered into a Medicaid Provider Agreement with the Department of Health. Current Business License	Certified by the LTCB as an authorized provider of services and supports.	1) Under State contract with LTCB as an authorized provider of services and supports. 2) Must complete a training course approved by the Bureau of Authorization and Community Based Services, State Medicaid Agency, and must demonstrate competency in related topical area(s) of: a) Self-determination b) Natural supports c) Instruction and/or consultation with families/siblings on: i) Assisting self sufficiency ii) Safety 3) Must be a professional with a bachelor's degree in social or behavioral sciences or a mental health professional with a master's degree in social or behavioral sciences.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Consumer Preparation Services	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and routinely scheduled monitoring if waiver providers thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Title:	**Financial Management Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

⦿	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Financial Management Services is 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:

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 consumer.

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

Service is provided to those utilizing Self Administered Services

Provider Specifications

Provider Category(s) *(check one or both)*:	☐ Individual. List types:	☑ Agency. List the types of agencies:
		Licensed Public Accounting Agency

Specify whether the service may be provided by *(check each that applies):*	☐ Legally Responsible Person	☐ Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Financial Management Services	Certified Public Accountant Sec 58-26A, UCA And R 156-26A, UAC	Certified by the LTCB as an authorized provider of services and supports.	• Under State contract with LTCB 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 Utah State Medicaid Agency. • 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 clients, their representatives, and others. • Document required Medicaid provider qualifications and enrollment requirements and maintain results in provider/employee file. • 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 case management agency. • 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 employee employment application package and documentation. • Utilize and accounting information system to invoice and receive Medicaid reimbursement funds. • Utilize and 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 Medicaid recipient or representative semi-annually. • Withhold, file and deposit FICA, FUTA and SUTA taxes in accordance with

			federal IRS and 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 tax year by January 31st. • File and deposit federal and state income taxes in accordance with federal IRS and state rules and regulations. • Assure that employees are paid established unit rates in accordance with the federal and state Department of Labor Fair Labor Standards Act (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 byt 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.

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 routinely scheduled monitoring if waiver providers thereafter.**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

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).*

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.

☐	**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. *Furnish the information specified above.*
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*
☐	**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. *Furnish the information specified above.*
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
☑	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Care Plan

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)*:

☑	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☑	Licensed physician (M.D. or D.O)
☑	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
⦿	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. *Specify*:
	Safeguards to ensure appropriate care plan development will include utilization of a standardized form, developed by the SMA, listing all services covered under the waiver as well as all potential providers of each service category available in the participants' area of residence. The form will also provide information that participants have the right to select a provider of services different than the entity developing the care plan. Waiver participants will sign the standardized form to acknowledge that they were informed of all services offered and given a choice of waiver providers. Forms will be reviewed as a component of the quality assurance monitoring completed by the SMA. Additionally a sample of participants will be interviewed to determine their satisfaction with the waiver program – offering choice of service providers is one element of data collected in the survey.

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.

The care plan is developed in consultation with the participant, the participant's legal representative, the participant's case management agency and any other individuals of the waiver participant's choosing.
The waiver participant will have care plan development information made available to them.

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 care plan is developed based upon the assessed needs of the waiver participant. The participant's needs are assessed by utilizing a standard comprehensive assessment instrument, the InterRAI MINIMUM DATA SET – HOME CARE. (MDS-HC) The MDS-HC provides a comprehensive assessment to identify the services and supports necessary to assure the health, welfare and safety of waiver participants. The comprehensive assessment is completed by the case management agency on participants' application to the waiver, at a minimum of annually (within the calendar month of the last level of care evaluation), and at any time a significant change in the participant's status occurs that necessitates an increase or decrease in services.

The care plan is developed in consultation with the participant, the participant's legal representative, the participant's and any other individuals of the waiver participant's choosing. The participant or legal representative will be advised of any needs identified during the assessment process and given the opportunity to accept or decline services that would address those needs. The participant will be provided with the standardized form listing all waiver services and waiver providers available in their area and given the opportunity to select their service providers.

The care plan will contain, at a minimum, the following information:

1. Care plan effective date;
2. Full name of the waiver participant;
3. Address;
4. Names of Case management agency participants;
5. List of all waiver services to be provided to the individual, regardless of the funding source;
6. The approved amount, frequency and duration for each service;
7. The type and name of qualified provider(s) selected to furnish each service;
8. Expected start date for each service;

Signatures of the waiver participant, the case management agency members, and the individual's legal representative, when applicable, are required on each of the completed assessments.

The participant selected Case Management agency will be responsible for implementing and coordinating the developed care plan. The care plan must be approved by the Operating Agency prior to implementation. Care plans will be reviewed as a component of the quality assurance monitoring completed by the SMA. Additionally a sampling of participants will be interviewed to survey their satisfaction with the waiver program.

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 case management agency, during the comprehensive needs assessment process and care plan development process will complete a risk analysis to identify: Risks posed by the participant's physical and cognitive 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 death or actual harm if an interruption in the delivery of a services and supports to the waiver participant occurred.

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

The backup plan lists three other backup contacts that can provide the service if the need arises. It also includes what the client will do if the Back-up Plan fails.

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.

Waiver participants will sign the standardized form, listing all waiver services and providers of those services in their area, to acknowledge that they were given a choice of waiver providers. These forms will be updated and provider information reviewed with the participant during the participants' annual MDS-HC assessment process and at any time there is a change in services. Forms will be reviewed as a component of the quality assurance monitoring completed by the SMA.

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 care planning process. The oversight function involves at a minimum an annual review of a sample of waiver enrollee's care plans that is representative of the caseload distribution across the program. If the sample evaluation identifies system-wide care planning problems, an expanded review is initiated by the SMA.

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:*

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
○	Every twelve months or more frequently when necessary
⦿	Other schedule (*specify*):
	The individual's care plan is screened at the time a substantial change in the individual's health status occurs to determine whether modifications to the care plan are necessary.

	A full care plan review is conducted: a. Whenever indicated by the results of a health status change screening; b. In conjunction with completion of a full comprehensive assessment; c. At a minimum of annually (within the calendar month of the last care plan) and within 14 days of annual MDS-HC. d. All revisions must be reviewed and approved by the Operating Agency prior to implementation

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)*:

☐	Medicaid agency
☐	Operating agency
☑	Case manager
☐	Other (*specify):*

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.

The case management agency has "front-line" responsibility for monitoring the health and welfare of waiver participants and to ensure the appropriate implementation of the care plan, including oversight to ensure that services are delivered within the scope, frequency, and duration described in the care plan. The assigned case manager from the case management agency will meet with the participant face to face as assessed necessary to insure the quality of services provided by the waiver service providers. Summarization of the performance of these oversight activities will be documented in the case management notes in the individual waiver participants' case files.

The Operating Agency is responsible to review and approve all care plans prior to implementation. All care plans are subject to annual and periodic reviews by the SMA. A sample of care plans will be reviewed periodically. Significant findings from those reviews will be addressed with the case management agencies. The case management agencies will be required to develop a plan of correction with specific timeframes for completion to address identified concerns. The SMA will conduct follow-up reviews as necessary to ensure the plan of correction is implemented and sustained.

b. Monitoring Safeguards. *Select one:*

○	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.
⦿	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. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	Safeguards to ensure appropriate care plan development will include utilization of a standardized form listing all potential providers of each service category. Waiver participants will sign the standardized form, which will be developed by the SMA, to acknowledge that they were given a choice of waiver providers. The case management agency will be required to maintain these forms in their files. These forms will be reviewed as a component of the quality assurance monitoring completed by the OA and the SMA. Additionally a sampling of participants will be interviewed to verify that they were given a choice of providers and in order to survey their satisfaction with the waiver program – offering choice of service providers is one element of data collected in the survey.

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/Sub-assurances**

a.i.a 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/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:	***The number and percentage of care plans in a representative sample which address the needs identified in the full assessment.***		
Data Source **MDS-HC** **Care Plan**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	

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Effective Date	

	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: at a minimum every five years.*	

Performance Measure #2:	***The number and percentage of care plans in a representative sample in which State plan services and other resources, for which the individual is eligible, are exhausted prior to authorizing the same service offered through the waiver.***		
Data Source **Care Plan**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	

State:	
Effective Date	

		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: at a minimum every five years.*	

a.i.b Sub-assurance: The State monitors care plan development in accordance with its policies and procedures.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:	***The number and percentage of annual care plans in a representative sample that are updated, at a minimum, within 14 days of the annual MDS-HC***		
Data Source **Care Plan** **MDS-HC**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ *Other: Describe*

State:	
Effective Date	

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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: at a minimum every five years.*	

a.i.c Sub-assurance: Care plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs..

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:	***The number and percentage of care plans in a representative sample that are updated, at a minimum, annually (within the calendar month of the last care plan).***		
Data Source **Care Plan** **Participant Records**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	☑ *Operating Agency*	☐ *Monthly*	*Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*Representative Sample; Confidence Interval*
	☐ *Other: Specify:*	☐ *Annually*	

State:	
Effective Date	

		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			x☐ *Other: Describe* *OA: 100%* *SMA: Less than 100%* *C.I = 5*
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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: at a minimum every five years.*	

Performance Measure #2:	***The number and percentage of care plans in a representative sample that are updated when warranted by changes in the waiver participant's needs.***		
<u>Data Source</u> **Care Plan** **Participant Records**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐*100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	

State:	
Effective Date	

		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: at a minimum every five years.*	

a.i.d Sub-assurance: Services are delivered in accordance with the care plan, including the type, scope, amount, duration and frequency specified in the care plan.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:	***The number and percentage of participants in a representative sample whose record contains documentation they were contacted by their Case Managers, monthly, either by phone or in person to monitor the delivery and quality of services provided.***		
Data Source	***Responsible Party for data***	***Frequency of data collection/generation:***	***Sampling Approach*** *(check each that*

Care Plan **Participant Records**	***collection/generation*** *(check each that applies)*	*(check each that applies)*	*applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: at a minimum every five years.*	

Performance Measure #2:	***The number and percentage of care plans in a representative sample that identify the amount, frequency and duration for each waiver service***.		
<u>Data Source</u> **Care Plan** **Participant**	***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)*

State:	
Effective Date	

Records			
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: at a minimum every five years.*	

a.i.e Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:	***The number and percentage of participants in a representative sample who were offered the choice between institutional care and home and community based waiver services as documented on the "Freedom of Choice Consent Form".***		
Data Source ***Freedom of Choice Consent Form***	***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)*
	☑ State Medicaid Agency	*☐ Weekly*	*☐100% Review*
	☑ Operating Agency	*☐ Monthly*	*☑ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☑ Representative Sample; Confidence Interval = 5*
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☑ Other: Specify: *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ 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*	
	☑ State Medicaid Agency	*☐ Weekly*	
	☑ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		☑ Other: Specify: *OA: Annually* *SMA: at a minimum every five years.*	

State:	
Effective Date	

Performance Measure #2:	***The number and percentage of participants in a representative sample who were offered the choice between available waiver providers as documented on the "Freedom of Choice of Waiver Providers Form".***		
Data Source **Care Plan** **Participant Records**	***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)*
	☑ State Medicaid Agency	*☐ Weekly*	*☐100% Review*
	☑ Operating Agency	*☐ Monthly*	*☑ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☑ Representative Sample; Confidence Interval = 5*
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☑ Other: Specify: *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ 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*	
	☑ State Medicaid Agency	*☐ Weekly*	
	☑ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		☑ Other: Specify: *OA: Annually* *SMA: at a minimum every five years.*	

Performance Measure #3:	***The number and percentage of participants in a representative sample who received a list of all NCW services as documented on the "Freedom of Choice of Waiver Providers Form".***

State:	
Effective Date	

Data Source **Care Plan** **Participant Records**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: at a minimum every five years.*	

a.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 conducts an annual review of the New Choices Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The

comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the OA and SMA review findings as well as other issues that develop during the review year. The sample size for the first year review will be sufficient to provide a confidence level equal to 95%, a response distribution of 50% , and a confidence interval equal to 5. For future years, the State will request a lower response distribution based on the statistical evidence of previous reviews.

b. Methods for Remediation/Fixing Individual Problems

b.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 the SMA and the OA, that affect the health and welfare of individual participants are addressed immediately. Issues that are less immediate are corrected within designated time frames and are documented through the SMA final review report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained by the SMA.

b.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)*
	☑ *State Medicaid Agency*	☐ *Weekly*
	☑ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		☑ *Other: Specify:* *OA: Annually.* *SMA: At a minimum every five 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 Level of Care that are currently non-operational.

○	**Yes** *(complete remainder of item)*
⦿	**No**

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

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

⦿	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
○	**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):

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
⦿	**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.

Participant direction will be limited to participation in decision-making related to employer related activities. The waiver will not involve participation in budget decision making.
The State authorized waiver services to be provided through two service delivery methods as defined below:
Agency Based Provider Service delivery means the provision of services through a licensed or certified agency or through a contracted vendor. Under this method, participants choose from which provider they wish to receive services. Services are then provided by the chosen agency. It is then the responsibility of the provider agency to perform the functions of supervising, hiring, assuring that provider qualifications are met, scheduling, paying the wages, etc. of the agency's employees. All waiver service categories are available under the Agency Based Provider Service delivery method.

Self-Administered Services* means service delivery that is provided through a non-agency based provider. Under this method, the individuals and/or their chosen representatives hire individual employees to perform a waiver service/s. The individual and/or their chosen representative are then responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheet, etc. of the individual employee/s.

In the case of an individual who cannot direct his or her own services, another person may be appointed as the decision-maker in accordance with applicable State law. The appointed person must perform supervisory activities at a frequency and intensity specified in the care plan. The appointed person may also train the employee to perform assigned activities.

The Self-Administered Service method requires the individual to use a Financial Management Services provider as an integral component of the waiver service to assist with managing the employer-related financial responsibilities associated with the delivery of self-administered services.

Appendix E-1(g) identifies services that are available under the Self-Administered Services method.

* Individuals authorized to receive services under the Self Administered Services method may also receive services under the Agency Based Provider Service method in order to obtain the array of services that best meet the individual's needs.

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

⦿	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** 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.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, 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.
○	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

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

☑	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☑	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.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

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

○	Waiver is designed to support only individuals who want to direct their services.
○	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.
⦿	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. *Specify the criteria*:
	1. Participants may only choose to direct the covered waiver services listed in E-1(g). 2. Participants must acknowledge the obligation of the State to assure basic health and safety and agree to abide by necessary safeguards negotiated during the risk assessment/care planning process. 3. In the case of an individual who cannot direct his or her own waiver services, another person may be appointed as the decision-maker in accordance with applicable State law.

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.

A two-stage approach will be used to inform each individual about the overall self-administered approach available through the waiver and about specific details of the process through which an individual can choose to self-administer to the degree desired.

Initially, the SMA Health Program Representative will provide a general orientation to the self-administered approach, including written materials, to each individual during the waiver eligibility determination and enrollment process. At that time information will be provided regarding the freedom to choose self-administered services, the mandatory use of a Financial Management Agent, and the responsibilities of the waiver enrollee and the case management agency related to self-administration.
During the comprehensive needs assessment process, the case management agency will identify each individual's needs that can be addressed through one or more of the available self-administered waiver services. The case management agency will inform the individual of the opportunity to utilize self-administration for the identified services and discuss the option to directly employ the provider or to utilize an agency based provider.

Upon the decision of the individual to utilize self-administration, the case management agency will assist the individual in selecting a financial management services provider to be used in conjunction with self-administration.

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

○	The State does not provide for the direction of waiver services by a representative.	
⦿	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:	
	☑	Waiver services may be directed by a legal representative of the participant.
	☑	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		Individual's possessing decision making capability, but having communication deficits or Limited English Proficiency (LEP) may select a representative to communicate decisions on the individual's behalf.

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-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Homemaker Services	☑	☐
Non-residential Respite Care Services	☑	☐
Chore Services	☑	☐
Personal Attendant Services	☑	☐
	☐	☐
	☐	☐

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:*

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

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

⦿	FMS are covered as the waiver service entitled	Financial Management Services
	as specified in Appendix C-3. *Provide the following information:*	

○	FMS are provided as an administrative activity. *Provide the following information:*	
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 service.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
	Payment for FMS is a monthly unit that is paid to the providers.	
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	
	Supports furnished when the participant is the employer of direct support workers:	
	☑	Assist participant in verifying support worker citizenship status
	☑	Collect and process timesheets of support workers
	☑	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
	☑	Other *(specify):*
		In support of self-administration, Financial Management Services will assist individuals in the following activities: 1. Verify that the employee completed the following forms 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. 3. Provide persons with a packet of all required forms when using a Financial Management Services provider, including all tax forms (IRS Forms I-9, W-4 and 2678), payroll schedule, Financial Management Services provider's contact information, and training material for the web-based timesheet. 4. Process and pay approved employee timesheets, including generating and issuing paychecks to employees hired by the person. 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 Financial Management Services 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 Financial Management Services 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. 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 Financial Management Services provider must obtain federal designation as Financial Management Services provider under IRS Rule 3504, (Acts to be Performed by Agents). A Financial Management Services provider applicant must make an election with the appropriate IRS Service Center via Form 2678, (Employer Appointment of Agent). The Financial Management Services provider must carefully consider if they want to avail the Employers of the various tax relief provisions related to domestics and family employers. The Financial Management Services 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 Financial Management Services provider will, if required, comply with IRS Regulations 3306(a)(3)(c)(2), 3506 and 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 Revenue Procedures; Rev. Proc. 70-6 allows the Financial Management Services provider file one employment tax return, regardless of the number of employers they are acting for, provided the Financial Management Services provider has a properly executed Form 2678 from each Employer. Rev. Proc 80-4 amplifies 70-6, and does away with the multiple Form 2678
	Supports furnished when the participant exercises budget authority:	
	☐	Maintain a separate account for each participant's participant-directed budget
	☐	Track and report participant funds, disbursements and the balance of participant funds
	☐	Process and pay invoices for goods and services approved in the service plan
	☐	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other services and supports *(specify)*:
	Additional functions/activities:	
	☑	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	☑	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	☑	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other *(specify)*:

iv.	**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.	
	The State Medicaid Agency and the OA will assure that high standards are maintained by utilizing the following: surveys of clients, regular observation and evaluation by case managers, provider quality assurance reviews, and other oversight activities as appropriate.	

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)*:

☑	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
	During the comprehensive needs assessment process, the case management agency will identify each individual's needs that can be addressed through one or more of the available self-administered waiver services. The case management agency will inform the individual of the opportunity to utilize self-direction for the identified services and discuss the option to directly employ the provider or to utilize an agency based provider.
☑	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: **Consumer Preparation Services**
☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *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:*

k. Independent Advocacy *(select one)*.

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
⦿	**No.** Arrangements have not been made for independent advocacy.

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:

In the event the individual make a voluntary declaration to terminate self-direction of one or more waiver services, the case management provider will revise the care plan to address access to necessary services through agency based providers. This process will include all aspects of care plan development including participation by the participant and individuals of his or her choosing and offering choice of providers.

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

Prior to enrolling in self-administered services, the participant/representative is informed of their

responsibilities and the rules that must be followed in order to participate. The individual is provided with the Self-Administered Services Packet which outlines the rules for participating in self-administered services. In addition, the participant/representative is required to sign a self-administered services agreement which outlines the conditions which the participant must comply with in order to use the self-administered services method. Only after a participant has demonstrated an incapacity for self-administration, including the inability to perform the essential functions of managing employees, hiring, training, scheduling or firing etc. or problems with fraud or malfeasance have been identified and has no qualified appointed person to direct the services on behalf of the participant, would involuntary termination of self-administered services occur. Prior to that occurrence however, the state offers participants who are struggling with self-administering their services assistance through case managers and/or Consumer Preparation Services.

Health and welfare and continuity of services are assured during the transition process because the consumer continues to receive services under the self-administered services method until the transfer to the agency-based provider method is made.

This process will include all aspects of care plan development including participation by the participant and individuals of his or her choosing and offering choice of providers.

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	30	
Year 2	35	
Year 3	40	
Year 4 (renewal only)	45	
Year 5 (renewal only)	50	

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. *Check each that applies:*

☐	**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. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee:*
☑	**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.

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

☑	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
☑	Hire staff (common law employer)
☐	Verify staff qualifications
☑	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	The employee pays for the BCI
☑	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☑	Determine staff duties consistent with the service specifications in Appendix C-3.
☑	Determine staff wages and benefits subject to applicable State limits
☑	Schedule staff
☑	Orient and instruct-staff in duties
☑	Supervise staff
☑	Evaluate staff performance
☑	Verify time worked by staff and approve time sheets
☑	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)

☐	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. *Check all that apply*:

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's established limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	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.

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.

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

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

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:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 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.

1. Upon the individual's choice of home and community based services, the case management agency conducts a comprehensive assessment. The comprehensive assessment identifies; (a) the individual's needs related to assuring health, welfare, and safety in a home or community setting in lieu of institutionalization and (b) the individual's goals related to enhancing community integration and quality of life.
2. The individual is informed of the results of the assessment and the specific needs identified as related to assuring health, welfare, and safety in a home or community setting in lieu of institutionalization.
3. The individual is informed that the SMA provides an opportunity for a fair hearing, under 42 CFR Part 431, Subpart E, to individuals who are not advised of the results of the comprehensive assessment or feel the assessment results do not accurately reflect the individual's needs related to assuring health, welfare, and safety in a home and community setting in lieu of institutionalization.
4. Written documentation of the individual's acknowledgement that the case management agency fully disclosed the results of the comprehensive assessment and the right to a fair hearing is documented.
5. From the comprehensive assessment, a written care plan is developed by the case management agency in accordance with Appendix D-1 to address the individual's identified needs through a specified array of services and supports. The written care plan may also incorporates other optional services and supports that are not primary to preventing institutionalization or protecting health and safety but will contribute in assisting the individual to achieve personal goals for independence and community integration. The care plan will identify these other services and support as optional and will identify funding sources other than Medicaid to cover any associated costs.
6. The individual is informed that the SMA provides an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are not advised of the content of the care plan, are not advised of the specific service providers responsible for providing identified services, or who feel the care plan does not accurately reflect the individual's needs related to assuring health, welfare, and safety in a home and community setting in lieu of institutionalization.
7. Written documentation of the individual's acknowledgement that the case management agency fully disclosed the results of the care plan development, afforded free choice of providers, and the right to a fair hearing is documented.

8. The Division of Medicaid and Health Financing provides an individual applying for or receiving waiver services an opportunity for a hearing upon written request, if the individual is:

   a) Not given the choice of institutional (NF) care or HCBS waiver services.

   b) Denied the waiver provider(s) of choice if more than one provider is available to render the service(s).

   c) Denied access to waiver services identified as necessary to prevent institutionalization.

   d) Experiences a reduction, suspension, or termination of waiver services identified as necessary to prevent institutionalization.

9. An individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from the Single State Medicaid Agency if the individual is denied a choice of institutional or New Choices Waiver program, or found ineligible for the waiver program. Copies of notices of adverse action are kept on file with the OA and with the Fair Hearings Unit within the SMA.

10. An individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from the contracted case management agency if the individual is denied access to the provider of choice for a covered waiver service. The Notice of Agency Action delineates the individual's right to appeal the decision.

11. An aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The Division of Medicaid and Health Financing may reinstate services for recipients or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than ten calendar days after the date of action.

12.. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the Department of Health for a formal hearing and determination. Participants are informed in the Utah Medicaid Member Guide that the Additional Dispute Resolution is not a pre-requisite for a Fair Hearing.

13. An informal dispute resolution process does not alter the requirements of the formal fair hearings process. The individual must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the Division of Medicaid and Health Financing. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for formal hearing, or be conducted concurrent with the formal hearing process.

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*:

⦿	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
○	**No**. This Appendix does not apply (*do not complete Item b)*

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 CMA will describe the participant's ability to contact the SMA constituent services line to discuss issues or concerns. The SMA constituent services representative will log the issue and will assign the review to the Bureau of Authorization and Community Based Services staff to review and follow-up as necessary. Documentation of the issue and outcome will be retained by the SMA.

Participants are encouraged to utilize the informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the a informal process at any time by completing a request for hearing and directing that the request be sent to the Department of Health for a formal hearing and determination.

Utilizing the informal dispute resolution process does not alter the time requirements for requesting a formal fair hearing. The participant must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the Division of Medicaid and Health Financing.

The informal dispute resolution activities will either be completed within the time limits allowed for filing a request for a fair hearing or the waiver participants will be advised of the need to file a request for a fair hearing within the allowed time limits and continue the informal dispute resolution process during the interim period until the fair hearing is actually scheduled and conducted.

Appendix F-3: State Grievance/Complaint System

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

⦿	**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 *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

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

The SMA is the agency responsible for the operation of the grievance/complaint system.

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).

Any type of grievance/complaint may be filed with SMA Constituent Services and there is no time limit to file. The grievance/complaint may be submitted via mail, email, or by phone. The SMA Constituent Services representative will log and assign the grievance/complaint. The SMA Constituent Services will work with the appropriate groups to address the grievance/complaint. Since each grievance/complaint is different the resolution timeline will vary. Once the grievance/complaint has been resolved the SMA Constituent Services or appropriate group will notify the complainant of the outcome. Documentation of the issue and outcome will be retained by the SMA.

The grievance/complaint resolution activities will either be completed within the time limits allowed for filing a request for a fair hearing or the waiver participants will be advised of the need to file a request for a fair hearing within the allowed time limits and the option to begin the informal dispute resolution process during the interim period until the fair hearing is actually scheduled and conducted.

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*:

⦿	**Yes**. The State operates a Critical Event or Incident Reporting and Management Process *(complete Items b through e)*
○	**No**. This Appendix does not apply (*do not complete Items b through e). 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.*

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).

State of Utah Reporting Requirements:

In accordance with section 62A-3-305 of the Utah State Code, any person who has reason to believe that any vulnerable adult has been the subject of abuse, neglect, or exploitation shall immediately notify Adult Protective Services intake or the nearest law enforcement agency.

State Medicaid Agency (DOH) Critical Event or Incident Reporting Requirements:

Any person, provider or other entity can report incidents.

The SMA requires that the OA report critical incidents/events within 24 hours or on the first business day after the event occurs either to or by a participant. Reportable incidents or events include: any unexpected or accidental deaths, all suicide attempts, medication errors that result in death, hospitalization or other serious outcomes, provider or caregiver abuse or neglect including self neglect that results in death, hospitalization or other serious outcomes, accidents that result in hospitalization, missing persons cases when immediate attempts to locate a participant have failed, human rights violations such as unauthorized use of restraints, criminal activities involving law enforcement that are performed by or perpetrated on waiver participants (including sexual abuse), events that compromise the participant's working or living environment that put a participant(s) at risk, Medicaid fraud investigations that involve any providers of services to waiver participants and

any waiver complaints referred by the Governor's office, constituent services or other elected officials. In addition, events that are anticipated to receive media, legislative, or other public scrutiny are required to be reported to the SMA immediately.

Operating Agency Critical Event or Incident Reporting Requirements:

The OA will notify the SMA of any critical events/incidents within 24 hours of the incident or on the first business day after the incident.

Participant Critical Event or Incident Reporting Requirements:

The participant will notify the CMA of any critical events/incidents within 24 hours of the incident or on the first business day after the incident.

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.

Annual trainings will describe participant's rights to be free from abuse, neglect and exploitation, the State's definitions of abuse, neglect and exploitation, the responsibilities of participants, case managers and other waiver services providers, and all other entities covered by State law to report suspected incidents, and the processes to be followed by participants or on behalf of participants in reporting suspected incidents.

Consumer Preparation Services provides the participant with information/training on the following topics:

1. how to avoid theft/security issues
2. maintaining personal safety when recruiting/interviewing potential employees
3. assertiveness/boundaries/rules with employees
4. maintaining personal safety when firing an employee
5. when and how to report instances of abuse, neglect, exploitation
6. resources on a local level to assist the participant if they are a victim of abuse, neglect or exploitation

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receive 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.

1. Initial reports of suspected abuse, neglect, or exploitation must be reported to the State's Adult Protective Services Agency or the local law enforcement agency in accordance with R510-302.

2. Persons observing suspected abuse, neglect, or exploitation must comply with reporting guidelines contained R510-302. The SMA will define incident reporting policy that requires

reporting to the SMA within 24 hours of occurrence or the next business day.

. After reviewing the information provided describing the critical incident/event, the SMA will determine on a case-by case basis if form Critical Incident/Event Investigation should be completed by the OA. The SMA will send the form to the OA and the OA representative will complete the investigation form and return it to the SMA within two weeks. The SMA will review the information provided by the OA and determine if additional information or action is warranted. The SMA will then complete the Critical Incident/Event Final SMA Report which describes the critical incident/event based on the evidence reviewed including evidence provided by incident reports, Medicaid Fraud investigation reports, licensing reports, etc. The Critical Incident/Event Final SMA Report also describes remediation activities that were developed and implemented to address the incident/event, including changes to care plans and systemic changes implemented by providers and/or the OA. Finally, the Critical Incident/Event Final SMA Report describes any SMA findings and an assessment of the OA's response to the incident/event, including whether the provider and OA responded appropriately to the incident/event, and identifies any systemic issues that require a plan of correction. The plan of correction will include the interventions to be taken and the time frame for completion. All plans of correction are subject to approval by the SMA. The SMA will conduct follow-up activities to determine that systems corrections have been achieved and are sustaining. Participants and/or legal representatives are informed in writing of the investigation results within two weeks of the closure of the investigation by the SMA.

3. The SMA will develop an incident report data collection and management system by July 1, 2010. At a minimum, annual reports will be generated to identify trends.

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.

1. Suspected incidents of abuse, neglect or exploitation – Adult Protective Services Agency, Utah Department of Human Services as per R510-302, UC 62A-3-302.
2. The SMA will be responsible for the oversight of incident reporting. Incident reports will be submitted to the SMA within 24 hours of occurrence or the next business day.
. The SMA will review, track and compile information into an electronic data base. At a minimum of annually, reports will be generated to identify trends and potential areas for quality improvement.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion *(select one):*

⦿	The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:
	Assisted Living rule R432-270-9(5)(c) states that residents have the right to be free from chemical and physical restraints. R432-270-9(5)(p) also states that residents have the right to leave the facility at any time and not be locked into any room, building, or on the facility premises during the day or night. Currently, assisted living facilities are surveyed annually by The Bureau of Health Facility Licensing, Certification and Resident Assessment (HFLCRA) nursing and social work staff. During these surveys, residents are observed in their daily environment and interviewed to determine facility compliance with these rules. HFLCRA also investigates complaints pertaining to restraints and seclusion in facilities. Restraints and seclusion issues, if found, are cited as a Class I deficiency - which is defined as: a violation that presents imminent danger to patients or residents. HFLCRA requires that these violations must be corrected immediately. In addition, the SMA has a contract with HFLCRA to assure that New Choices Waiver recipients are included in the licensing review sample. If a specific issue is identified with a waiver participant during the licensing review, HFLCRA notifies the SMA immediately.
○	The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints or Seclusion. 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 or seclusion). 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 or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

b. Use of Restrictive Interventions

⦿	The State does not permit or prohibits the use of restrictive interventions. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

	Assisted Living rule R432-270-9(5)(a) states that residents have the right to be to be treated with respect, consideration, fairness, and full recognition of personal dignity and individuality. R432-270-9(5)(p) also states that residents have the right to leave the facility at any time and not be locked into any room, building, or on the facility premises during the day or night. Currently, assisted living facilities are surveyed annually by HFLCRA nursing and social work staff. During these surveys, residents are observed in their daily environment and interviewed to determine facility compliance with these rules. HFLCRA also investigates complaints pertaining to restrictive interventions in facilities. Restrictive intervention issues, if found, are cited as a Class I deficiency- which is defined as: a violation that presents imminent danger to patients or residents. HFLCRA requires that these violations must be corrected immediately. In addition, the SMA has a contract with HFLCRA to assure that New Choices Waiver recipients are included in the licensing review sample. If a specific issue is identified with a waiver participant during the licensing review, HFLCRA notifies the SMA immediately.
○	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-a-ii:

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:

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:

⦿	**Yes**. This Appendix applies *(complete the remaining items)*.
○	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

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.

The case management agency has primary responsibility for monitoring participant medication regimens. This monitoring process consists of reviewing the participant's medication administration sheets at the assisted living facility to assure medications are being given as prescribed. In addition, periodic reviews to look for things like medication interactions or appropriate medication related laboratory testing are conducted as well. This is accomplished through ongoing interaction with the participant and provider of residential care services. The case management agency will address concerns with residential care service providers directly and document interaction and outcome. This record will be maintained and reviewed as part of the QA process. The case management agency will notify the OA for additional follow up should issues remain unresolved.

Assisted Living rule R432-270-19 delineates the requirements for medication administration. Currently, assisted living facilities are surveyed annually by HFLCRA nursing and social work staff. During these surveys, medication records are reviewed, and residents are observed in their daily environment and interviewed to determine facility compliance with these rules. HFLCRA also investigates complaints pertaining to issues with medication errors in facilities. Serious medication errors, if found, are cited as a violation. HFLCRA will require corrective actions. In addition, the SMA entered into a contract with HFLCRA to assure that New Choices Waiver recipients are included in the licensing review sample. If a specific issue is identified with a waiver participant during the licensing review, HFLCRA notifies the SMA immediately.

The SMA monitors critical incidents/events that occur when a medication error results in hospitalization, death or other serious outcomes. These critical incidents/events are reported to the SMA which conducts investigations of all medication critical incidents/events on an ongoing basis. The SMA monitors any medication issues that affect a participant's health and welfare during the full waiver comprehensive review which is conducted at a minimum every five years.

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.

The SMA is responsible for overseeing the performance of case management providers in assisting participants to properly manage medication regimes. Performance of providers in assisting participants to properly manage medication regimes and the performance of the case management agency in proper primary oversight is incorporated in the comprehensive quality monitoring program of the SMA and is a performance measure scrutinized during on-site reviews of the case management agency and during reviews of periodic quality assurance reports provided by the case management agency in summarizing its internal quality assurance activities.

c. Medication Administration by Waiver Providers

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

⦿	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. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

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).

Medication Administration – All waiver providers are required to comply with the State's administrative rules governing medication administration including the State's Nurse Practice Act.
The State's administrative rules and Nurse Practice Act also apply to relatives providing the care as a paid service. Since a provider administering medication is required to be a licensed or certified professional as described in the state's administrative rules or Nurse Practice Act, unless a relative has the required licensure or certification they are not allowed to administer medications as a component of a paid waiver service.

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

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
⦿	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:
	As per Administrative Rule - R432-270-19. Medication Administration. The SMA also requires that medication errors resulting in hospitalization, death or other serious outcomes are reported as per the Critical Incident/Events Reporting Protocol. The state does not have a rule that delineates the type of medication errors that providers are required to report.

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.

The SMA will be the agency responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants. Medication errors that result in death, hospitalization or other serious outcomes are critical incidents/events that must be reported to the SMA. The SMA reviews 100% of these critical incident/event medication errors on an ongoing basis. The SMA also collects critical incident/event medication data on an ongoing basis. Annually, the SMA aggregates and analyses the data and identifies any systemic issues. These issues are addressed either by requiring a plan of correction from the OA or the implementation of a quality improvement initiative. The plans of correction will include the interventions necessary to correct the issues and time frames for completion. All plans of correction are subject to approval by the SMA. The SMA will conduct follow-up activities to determine that systems corrections have been achieved and are sustaining.

The SMA will also contract with case management services providers. The contract will include the requirement for the case management services providers to monitor the quality of services provided to include oversight of waiver providers responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. Additionally, the SMA will conduct a quality assurance review of a sample of waiver participant cases. Medication administration processes will be monitored during these quality assurance reviews.

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, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

a.i *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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:	***The number and percentage of referrals in a representative samples made to Adult Protective Services and/or law enforcement, according to state law, when there was reason to believe that abuse, neglect and/or exploitation had occurred.***		
Data Source **Incident Reports** **Participant Interviews (PES)** **Participant Records**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	

State:	
Effective Date	

		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually* *SMA: at a minimum every five years.*	

Performance Measure #2:	***The number and percentage of critical incidents and events in a representative sample in which the SMA was notified by the OA per the "Protocol: Critical Incidents and Events Notification to SMA"***		
<u>Data Source</u> **Incident Reports** **Participant Interviews (PES)** **Participant Records**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	

State:	
Effective Date	

		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify: OA: Annually SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify: OA: Annually SMA: at a minimum every five years.*	

Performance Measure #3:	***The number and percentage of incidents in a representative sample in which the case manager, when warranted, put effective safeguards and interventions in place that address the participant's health and welfare needs.***		
<u>Data Source</u> **Incident Reports** **Participant Interviews (PES)** **Participant Records**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	

State:	
Effective Date	

		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify: OA: Annually SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify: OA: Annually SMA: at a minimum every five years.*	

Performance Measure #3:	***The number and percentage of cases in a representative sample in which the case manager verified the effectiveness of new safeguards and interventions following an incident.***		
Data Source **Incident Reports** **Participant Interviews (PES)** **Participant Records**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and*	☐ *Stratified:*

		Ongoing	*Describe Groups*
		☑ Other: Specify: *OA: Annually* *SMA: At a minimum every 5 years*	
			☐ 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*	
	☑ State Medicaid Agency	*☐ Weekly*	
	☑ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		☑ Other: Specify: *OA: Annually* *SMA: at a minimum every five years.*	

Performance Measure #4:	***The number and percentage of participants using the self-administered model for service delivery in a representative sample for which the Emergency Back-up Plan Form was completed and current.***		
<u>Data Source</u> **Incident Reports** **Participant Interviews (PES)** **Participant Records**	***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)*
	☑ State Medicaid Agency	*☐ Weekly*	*☐100% Review*
	☑ Operating Agency	*☐ Monthly*	*☑ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☑ Representative Sample; Confidence Interval = 5*
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and	*☐ Stratified:*

		Ongoing		*Describe Groups*
		☑ Other: Specify: *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*		
				☐ 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*		
	☑ State Medicaid Agency	*☐ Weekly*		
	☑ Operating Agency	*☐ Monthly*		
	☐ Sub-State Entity	*☐ Quarterly*		
	☐ Other: Specify:	*☐ Annually*		
		☐ Continuously and Ongoing		
		☑ Other: Specify: *OA: Annually* *SMA: at a minimum every five years.*		

a.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.

Referrals are made to Adult Protective Services (APS) and/or law enforcement according to state law. Prevention strategies are developed and implemented, when warranted, when abuse, neglect and/or exploitation are reported. Case managers work closely with local APS workers to resolve issues. When a case manager reports or becomes aware of a referral made to APS about a New Choices Waiver participant, the case manager informs the OA as soon as possible and documents the notification in the participant's record. The OA reviews this information and provides the information to the SMA.

The SMA and the OA follow the SMA Critical Incidents and Events Protocol to: 1) assure that appropriate actions have taken place when a critical incident or event occurs; and/or 2) in cases where appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard participants. Within 24 hours or on the first business day after a critical incident or event has occurred to or by a participant, a representative from the Waiver Operating Agency will notify the SMA Quality Assurance representative via email, telephone or in person. After reviewing the information provided describing the critical incident/event, the SMA determines on a case-by-case basis if the incident or event requires an investigation. In cases where further investigation is required the operating agency completes the form "Critical Incident/Event Findings Operating Agency Report to SMA". The SMA reviews the information provided by the Operating Agency and determines if any additional information or action is required. A final report is developed which contains: 1) a summary describing the incident/event based on all evidence reviewed, including evidence provided by the Medicaid Fraud Control Unit, Licensing. log notes etc. 2) Remediation

Activities, describing the remediation activities that were developed and implemented to address the incident/event, including changes to care plans and systemic changes implemented by the operating agency and/or provider. 3) SMA Findings and Recommendations including an assessment of the operating agency's response to the incident/event and the identification of any issues related to reporting protocols. The SMA notifies the Operating Agency representative when the critical incident/event has been resolved.

The SMA conducts an annual review of the New Choice Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the OA and SMA review findings as well as other issues that develop during the review year. The sample size for the first year review will be sufficient to provide a confidence level equal to 95%, a response distribution of 50% , and a confidence interval equal to 5. For future years, the State will request a lower response distribution based on the statistical evidence of previous reviews.

b. Methods for Remediation/Fixing Individual Problems

b.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 the SMA and the OA, that affect the health and welfare of individual participants are addressed immediately. Issues that are less immediate are corrected within designated time frames and are documented through the SMA final review report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained by the SMA.

b.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)*
	☑ *State Medicaid Agency*	☐ *Weekly*
	☑ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		☑ *Other: Specify:* *OA: Annually.* *SMA: At a minimum every five 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 Level of Care that are currently non-operational.

○	**Yes** *(complete remainder of item)*
⦿	**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.

Appendix H: Systems Improvement

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.

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 QMS 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 QMS* 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.

H.1 Systems Improvement

H.1.a.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 assurance being evaluated.

The State will develop an Action Plan for the development of a cost reporting tool to assure financial oversight of program expenditures. The Action plan will include timelines and milestone dates.

H.1.a.ii

System Improvement Activities	***Responsible Party*** *(check each that applies*	***Frequency of monitoring and analysis*** *(check each that applies*
	☑ *State Medicaid Agency*	☐ *Weekly*
	☑ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☑ *Quality Improvement Committee*	☐ *Annually*
	☐ *Other: Specify:*	☑ *Other: Specify: Third year of waiver operation*

H.1.b.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, and how the results of the changes and the assessment are communicated (and with what frequency) to stakeholders, including participants, families, providers, agencies and other interested parties. 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 OA, and 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 system design changes will be communicated to participants and families, providers,

agencies and others through the Medicaid Information Bulletin and the New Choices Waiver website.

H.1.b.ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy is a dynamic document that is continuously evaluated each year by the SMA's quality management 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 the 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 New Choices waiver. Improvements to the QIS will be made at this time and submitted in the following waiver renewal application.

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 SMA 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.

Post-payment reviews are conducted by the SMA reviewing a sample of individual written care plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the care plan, (2) that the individual is receiving the services identified in the care plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the care plan.

The State will develop an Action Plan for the development of a cost reporting tool to assure financial oversight of program expenditures. The Action plan will include timelines and milestone dates.

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**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

a.i *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include*

numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:	***The number and percentage of claims, in a representative sample paid for services identified on a participant's Comprehensive Care Plan.***		
Data Source **Care Plans** **Claims Data**	***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)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☑ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☑ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify:* *OA: Annually*	

		SMA: at a minimum every five years.	
Performance Measure #2:	***The number and percentage of claims, in a representative sample paid for services that do not exceed the amount, frequency and duration identified on the participant's Comprehensive Care Plan.***		
Data Source **Care Plans** **Claims Data**	***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)*
	☑ State Medicaid Agency	*☐ Weekly*	*☐100% Review*
	☑ Operating Agency	*☐ Monthly*	*☑ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☑ Representative Sample; Confidence Interval = 5*
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☑ Other: Specify: *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ 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*	
	☑ State Medicaid Agency	*☐ Weekly*	
	☑ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		☑ Other: Specify: *OA: Annually* *SMA: at a minimum every five years.*	

Performance Measure #3:	***Number and percentage of participant claims in a representative sample that paid for services using the correct HCPCs as identified on the comprehensive care plan.***		
Data Source **Care Plans** **Claims Data**	***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)*
	☑ State Medicaid Agency	*☐ Weekly*	*☐100% Review*
	☑ Operating Agency	*☐ Monthly*	*☑ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☑ Representative Sample; Confidence Interval = 5*
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☑ Other: Specify: *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*	
			☐ 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*	
	☑ State Medicaid Agency	*☐ Weekly*	
	☑ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		☑ Other: Specify: *OA: Annually* *SMA: at a minimum every five years.*	

Performance Measure #4:	**Number of recoveries in a representative sample that are returned to the federal government in accordance with federal regulations.**		
Data Source	***Responsible Party for***	***Frequency of data***	***Sampling Approach***

Care Plans **Claims Data**	***data collection/generation*** *(check each that applies)*	***collection/generation:*** *(check each that applies)*	*(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☑ *Other: Specify: SMA: At a minimum every 5 years*	
			☐ *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*	
	☑ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☑ *Other: Specify: SMA: at a minimum every five years.*	

a.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 conducts an annual review of the New Choices Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from the OA and SMA review findings as well as other issues that develop during the review year. The sample size for the first year review will be sufficient to provide a confidence level equal to 95%, a response distribution

of 50% , and a confidence interval equal to 5. For future years, the State will request a lower response distribution based on the statistical evidence of previous reviews.

b. Methods for Remediation/Fixing Individual Problems

b.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.*

Recovery of Funds:

- When payments are made for a service not identified on the Comprehensive Care Plan: a recovery of unauthorized paid claims based upon the Federal Medical Assistance Percentage (FMAP) will be required.
- When the amount of payments exceeds the amount, frequency, and/or duration identified on the Comprehensive Care Plan: a recovery of unauthorized paid claims based upon the Federal Medicaid Percentage (FMAP) will be required.
- 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.

When the OA discovers that unauthorized claims have been paid, the OA works with Medicaid Operation and Medicaid Operations reprocess the MMIS claims to reflect the recovery. The OA will then notify the SMA of the recovery.

When the SMA discovers that unauthorized claims have been paid, the recovery of funds will proceed as follows:

1. The State Medicaid Agency will complete a Recovery of Funds Form that indicates the amount of the recovery and send it to the Operating Agency.
2. The Operating Agency will review the Recovery of funds form and return the signed form to the State Medicaid Agency.
3. Upon receipt of the Recovery of Funds Form, the State Medicaid Agency will submit the Recovery of Funds Form to Medicaid Operations.
4. Medicaid Operations will reprocess the MMIS claims to reflect the recovery.
5. Overpayments are returned to the federal government within 60 days of discovery.

b.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)*
	☑ *State Medicaid Agency*	☐ *Weekly*
	☑ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and*

		Ongoing
		☑ *Other: Specify:* *OA: Annually.* *SMA: At a minimum every five 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 Level of Care that are currently non-operational.

○	**Yes** *(complete remainder of item)*
⦿	**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.

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).

Waiver rates are established by the State Medicaid Agency. Opportunity for public comment of the rates is available during the application renewal process and annually as the rates are adjusted. Information about payment rates will be communicated using provider bulletins and letters, annual public notices, annual waiver training, and the New Choices Waiver website.

Adult Day Care, Adult Residential, Attendant Care, Caregiver Training, Case Management, Chore, Consumer Preparation , Financial Management, Habilitation, Home Delivered Meals, Homemaker, Medication Assistance, Personal Budget Assistance, Personal Emergency Response System, Respite Care, , Supportive Maintenance, and Transportation Services
are reimbursed on a fee-for-service basis. Payment is based on a statewide fee schedule.

The rates for Assistive Technology Services, Community Transition Services, Specialized Medical Equipment and Supplies, and Environmental Accessibility Adaptations are negotiated by the case management agency on behalf of the Single State Agency. Allowable expenditures are based on the individual client need and are not to exceed the service limits.
Below is a list of the services and the rate information:

The following services were based on a 2009 market study:
Adult Residential Services

The following services were rebased in 2005 and have received COLA adjustments:
Adult Day Care
Habilitation Services
Home Delivered Meals
Case Management Service

Chore Services
Attendant Care Services
Financial Management Services
Personal Budget Assistance
Respite Care
Medication Assistance Services
Caregiver Training

The following services are based on the State Plan rate:
Supportive Maintenance

The following services were based on a 1997 cost study and have received COLA adjustments:
Homemaker
Consumer Preparation Services

The following services are paid using the actual cost of the service:
Assistive Technology Services
Environmental Accessibility Adaptations
Community Transition Services
Specialized Medical Equipment and Supplies

The following services are paid using a Competitive Contract written in 2005 with slight increase in an amendment in 2007:
Personal Emergency Response System

The following services are paid using the Utah Transportation Authority rate:
Transportation - Non Medical (Per One-Way Trip)
Transportation - Non Medical (Public Transit Pass)

The following service is paid using the State of Utah Employee mileage reimbursement:
Transportation - Non Medical (Per Mile)

All service rates are posted on the state's HCBS waiver website and rate change notices are published in newspapers and in the Utah State Bulletin which is located at rules.utah.gov.

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:

Waiver services providers submit claims directly to the SMA, the SMA then pays the waiver service provider directly.

For individuals participating in the self-administered services delivery method, the participant submits their staff time sheet(s) to the FMS Agent. The FMS Agent pays the claim(s) and submits a bill to the SMA. The SMA reimburses the FMS.

c. Certifying Public Expenditures *(select one)*:

○		**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 (*check each that applies*):
	☐	**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). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	☐	**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). (*Indicate source of revenue for CPEs in Item I-4-b.*)

⦿	**No**. State or local government agencies do not certify expenditures for waiver services.	

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:

DESCRIPTION OF BILLING PROCESS AND RECORDS RETENTION

1. A participant's Medicaid eligibility is determined by the Office of Health and Eligibility within the Department of Workforce Services or the Bureau of Eligibility Services within the Department of Health. The information is entered into the Public Assistance Case Management Information System (PACMIS). PACMIS is an on-line, menu-driven system which automates Medicaid eligibility decisions, benefits amounts, participants' notices and administrative reports. PACMIS 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 PACMIS: Aid to Families with Dependent Children (AFDC), Medicaid, Food Stamps, and two state-administered programs - General Assistance and the Primary Care Network (PCN). The Medicaid Management Information System (MMIS) accesses PACMIS to ensure the participant is Medicaid eligible before payment of claims is made.

2. Post-payment reviews are conducted by the SMA reviewing a sample of individual written care plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the care plan, (2) that the individual is receiving the services identified in the care plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the care plan.

3. Prior to the order and delivery of Medicaid reimbursed approved specialized medical equipment, medical supplies, or assistive technology, the support coordinator must obtain prior approval based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

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.

APPENDIX I-3: Payment

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

⦿	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	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.
○	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:
○	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. Describe how payments are made to the managed care entity or entities:

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*):

☑	The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. 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:
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

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:*

⦿	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**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 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.*

⦿	**Yes.** State or local government providers receive payment for waiver services. 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. *Complete item I-3-e.*
	The state utilizes some county agencies (Area Agencies on Aging) as case management providers. All other providers are private.
○	**No**. State or local government providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

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*:

⦿	The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
○	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.
○	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:

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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:*

⦿	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

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

○	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
⦿	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

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

○	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. 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:
⦿	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

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

○	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 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.
○	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.
⦿	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

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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. *Check each that applies:*

☑	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**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:
☐	**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:

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. *Check each that applies:*

☐	**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:
☐	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; 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:
☑	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

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:*

☑	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.	
○	The following source (s) are used. *Check each that applies.*	
	☐	Health care-related taxes or fees
	☐	Provider-related donations
	☐	Federal funds
	For each source of funds indicated above, describe the source of the funds in detail:	

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

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

○	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
○	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

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:

Since the daily Medicaid reimbursement excludes all room and board costs, the individual waiver participants are responsible to pay room and board directly to their landlord/facility. Each participant has a rental agreement with the facility where they reside. This agreement breaks out the room and board portion that the client is responsible to pay to the facility.

To assure that the Medicaid rate was appropriately set and did not include room and board costs, Facility Cost Reports were obtained from each provider of Adult Residential Services. The reporting period was from May 1, 2007 through December 31, 2008.

The results of the facility cost report show that the total average daily base rate charged to a private pay client was $94.10. The total average daily cost for a New Choices Waiver client was $90.00. The average daily Medicaid service rate was $71.40 and the average daily room and board amount paid by the client was $18.60 or $558. Monthly room and board costs for a small one bedroom living arrangement totaling approximately $560 per month is consistent with the prevailing rental property rates in the state.

In comparing the prevailing market price for base rate assisted living services ($94.10) against the Medicaid rate ($71.40) paid for the basic services plus services that would result in additional add-ons to the private pay rate, the facility cost report findings demonstrate the Medicaid rate is reasonable.

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:

○	**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. *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:*
⦿	**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.

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:*

⦿	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

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

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

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. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	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:

v. Assurance. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

⦿	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**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:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:							
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	$22,584	$3,631	$26,215	$44,660	$5,361	$50,021	$23,806
2	$20,578	$3,704	$24,282	$45,553	$5,468	$51,021	$26,739
3	$20,990	$3,778	$24,768	$46,464	$5,578	$52,042	$27,274
4	$21,409	$3,853	$25,262	$47,394	$5,689	$53,083	$27,821
5	$21,837	$3,930	$25,767	$48,341	$5,803	$54,144	$28,377

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	1200		
Year 2	1400		
Year 3	1400		
Year 4 (renewal only)	1700		
Year 5 (renewal only)	1700		

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-d.

The average length of stay estimate is based on preliminary numbers for the actual average LOS during the State Fiscal Year 2009.

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:

Factor D is an estimate that is based off the actual preliminary utilization numbers for State fiscal year 2009. The average number of users per service was increased in proportion with the increase in the total available waiver slots. To project the actual 2009 average cost per unit data forward to 2011 the following equation was used: (actual 2009 average cost per unit) * ((1.02)^2). A cost of living adjustment of two percent has been added to each additional year to address inflation and is within the medical consumer price index. This data was entered into the Factor D tables for calculation.

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:

Factor D′ is an estimate that is based off the actual preliminary numbers for State fiscal year 2009. To project the actual 2009 data forward to 2011 the following equation was used: (actual 2009 D') * ((1.02)^2). A cost of living adjustment of two percent has been added to each additional year to address inflation and is within the medical consumer

price index. Factor D′ includes the Medicaid costs for all services that are furnished in addition to waiver services while the individual is in the waiver. This calculation includes institutional costs when a person leaves the waiver for the institution and returns to the waiver in the same waiver year. If a waiver participant does not return to the waiver following institutionalization, the cost of institutional care is not included. The costs of prescribed drugs for Medicare/Medicaid dual eligible clients under the provisions of Part D are also not included in the estimate.

The estimate shows that the D' is lower than the G' for the New Choices Waiver. This estimate is based off of the actual data of New Choices Waiver and nursing facility participants. The reason that the G' is not higher than the D' is the Nursing facility payments do not encompass all services that are furnished to their residents. For example doctor's appointments and hospital stays are not included in the nursing facility payment and are included in the G' costs.

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:

Factor G is an estimate that is based off the actual preliminary utilization numbers for State fiscal year 2009. Factor G is calculated utilizing the average annual institutional cost of services for a person receiving nursing facility level of care that is not intensive skilled. These are the same services that would be furnished to waiver participants in the absence of the New Choices Waiver. The average annual costs are then divided by the nursing facility ALOS to calculate the average cost per day. The average cost per day is then multiplied by the New Choices Waiver ALOS to get Factor G. To project the actual 2009 data forward to 2011 the following equation was used: (actual 2009 G) * ((1.02)^2). Also, a cost of living adjustment of two percent has been added to each additional year to address inflation and is within the medical consumer price index.

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:

Factor G' is an estimate that is based off the actual preliminary utilization numbers for State fiscal year 2009. Factor G' is calculated utilizing the average annual cost of all other (non institutional) Medicaid services furnished while the individual is in the nursing facility. The average annual costs are then divided by the nursing facility ALOS to calculate the average cost per day. The average cost per day is multiplied by the New Choices Waiver ALOS to get Factor G'. To project the actual 2009 data forward to 2011 the following equation was used: (actual 2009 G') * ((1.02)^2). Also, a cost of living adjustment of two percent has been added to each additional year to address inflation and is within the medical consumer price index. The costs of prescribed drugs for Medicare/Medicaid dual eligible clients under the provisions of Part D are also not included in the estimate.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

⦿	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	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

Waiver Year: Year 1

Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Adult Day Care	Day	5	50	$38.41	$9,603
Adult Residential Services (Assisted Living Facilities)	Day	950	273	$71.15	$18,452,753
Adult Residential Services (Certified Community Residential Care)	Day	140	273	$84.25	$3,220,035
Adult Residential Services (Licensed Community Residential Care)	Day	30	273	$105.32	$862,571
Assistive Technology Services	Per Item	6	1	$2,040.00	$12,240
Attendant Care Services	15 Minute	120	600	$3.09	$222,480
Caregiver Training	15 Minute	7	54	$4.98	$1,882
Case Management Service	15 Minute	1200	144	$20.40	$3,525,120
Chore Services	Per Service	8	10	$153.00	$12,240
Consumer Preparation Services	Hour	25	4	$56.63	$5,663
Environmental Accessibility Adaptations (Home Modifications)	Per service	5	1	$663.00	$3,315
Environmental Accessibility Adaptations (Vehicle modification)	Per service	5	1	$1,511.64	$7,558
Financial Management Services	Month	25	12	$48.96	$14,688
Habilitation Services	Hour	25	35	$23.10	$20,213
Home Delivered Meals	Per Meal	25	35	$5.99	$5,241
Homemaker Service	Hour	37	116	$20.25	$86,913
Institutional Transition Services	Per service	200	1	$742.56	$148,512
Medication Assistance Services (Medication Reminder System)	Month	15	12	$49.98	$8,996
Medication Assistance Services(Medication Set-up)	15 Minute	63	26	$20.16	$33,022
Personal Budget Assistance	15 Minute	400	48	$4.81	$92,352
Personal Emergency Response	Per Service	10	1	$43.53	$435

State:	
Effective Date	

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
System (Installation, Testing & Removal)					
Personal Emergency Response System (Purchase, Rental, Repair)	Per Item	10	1	$207.04	$2,070
Personal Emergency Response System (Response Center Service Fee)	Month	50	9	$32.66	$14,697
Respite Care (Client's Home)	Day	10	14	$57.85	$8,099
Respite Care (Room and Board Included)	Day	10	14	$141.27	$19,778
Respite Care (Routine)	Hour	10	96	$21.21	$20,362
Specialized Medical Equipment and Supplies	Per Item	300	4	$71.40	$85,680
Supportive Maintenance	Hour	10	50	$21.89	$10,945
Transportation - Non Medical (Per Mile)	Per Mile	10	1000	$0.37	$3,700
Transportation - Non Medical (Per One-Way Trip)	Per Trip	190	48	$15.24	$138,989
Transportation - Non Medical (Public Transit Pass)	Month	65	9	$85.68	$50,123
GRAND TOTAL:					$27,100,275
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1200
FACTOR D (Divide grand total by number of participants)					$22,584
AVERAGE LENGTH OF STAY ON THE WAIVER					273

State:	
Effective Date	

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Adult Day Care	Day	2	120	$39.18	$9,403
Adult Residential Services (Assisted Living Facilities)	Day	992	273	$72.57	$19,653,117
Adult Residential Services (Certified Community Residential Care)	Day	175	200	$85.94	$3,007,900
Adult Residential Services (Licensed Community Residential Care)	Day	47	175	$107.43	$883,612
Assistive Technology Services	Per Item	7	1	$2,080.80	$14,566
Attendant Care Services	15 Minute	128	500	$3.15	$201,600
Caregiver Training	15 Minute	6	54	$5.08	$1,646
Case Management Service	15 Minute	1400	144	$20.81	$4,195,296
Chore Services	Per Service	7	10	$156.06	$10,924
Consumer Preparation Services	Hour	6	4	$57.76	$1,386
Environmental Accessibility Adaptations (Home Modifications)	Per service	6	1	$676.26	$4,058
Environmental Accessibility Adaptations (Vehicle modification)	Per service	6	1	$1,541.87	$9,251
Financial Management Services	Month	29	12	$49.94	$17,379
Habilitation Services	Hour	35	60	$23.56	$49,476
Home Delivered Meals	Per Meal	35	152	$6.11	$32,505
Homemaker Service	Hour	48	181	$16.12	$140,051
Institutional Transition Services	Per service	117	1	$510.00	$59,670
Medication Assistance Services (Medication Reminder System)	Month	6	5	$50.98	$1,529
Medication Assistance Services(Medication Set-up)	15 Minute	18	60	$20.56	$22,205
Personal Budget Assistance	15 Minute	292	66	$4.91	$94,626
Personal Emergency Response System (Installation, Testing & Removal)	Per Service	12	1	$44.40	$533
Personal Emergency Response System (Purchase, Rental, Repair)	Per Item	12	1	$211.18	$2,534

State:	
Effective Date	

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Personal Emergency Response System (Response Center Service Fee)	Month	58	9	$33.31	$17,388
Respite Care (Client's Home)	Day	6	14	$59.01	$4,957
Respite Care (Room and Board Included)	Day	4	20	$144.10	$11,528
Respite Care (Routine)	Hour	6	70	$21.63	$9,085
Specialized Medical Equipment and Supplies	Per Item	233	4	$72.83	$67,878
Supportive Maintenance	Hour	12	50	$22.33	$13,398
Transportation - Non Medical (Per Mile)	Per Mile	12	1000	$0.38	$4,560
Transportation - Non Medical (Per One-Way Trip)	Per Trip	222	55	$15.54	$189,743
Transportation - Non Medical (Public Transit Pass)	Month	99	9	$87.39	$77,864
GRAND TOTAL:					$28,809,668
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1,400
FACTOR D (Divide grand total by number of participants)					$20,578
AVERAGE LENGTH OF STAY ON THE WAIVER					273

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Adult Day Care	Day	2	120	$39.96	$9,590
Adult Residential Services (Assisted Living Facilities)	Day	992	273	$74.02	$20,045,800
Adult Residential Services (Certified Community Residential Care)	Day	175	200	$87.66	$3,068,100
Adult Residential Services (Licensed Community Residential Care)	Day	47	175	$109.58	$901,296
Assistive Technology Services	Per Item	7	1	$2,122.42	$14,857
Attendant Care Services	15 Minute	128	500	$3.21	$205,440
Caregiver Training	15 Minute	6	54	$5.18	$1,678
Case Management Service	15 Minute	1400	144	$21.23	$4,279,968
Chore Services	Per Service	7	10	$159.18	$11,143
Consumer Preparation Services	Hour	6	4	$58.92	$1,414
Environmental Accessibility Adaptations (Home Modifications)	Per service	6	1	$689.79	$4,139
Environmental Accessibility Adaptations (Vehicle modification)	Per service	6	1	$1,572.71	$9,436
Financial Management Services	Month	29	12	$50.94	$17,727
Habilitation Services	Hour	35	60	$24.03	$50,463
Home Delivered Meals	Per Meal	35	152	$6.23	$33,144
Homemaker Service	Hour	48	181	$16.44	$142,831
Institutional Transition Services	Per service	117	1	$520.20	$60,863
Medication Assistance Services (Medication Reminder System)	Month	6	5	$52.00	$1,560
Medication Assistance Services(Medication Set-up)	15 Minute	18	60	$20.97	$22,648
Personal Budget Assistance	15 Minute	292	66	$5.01	$96,553
Personal Emergency Response System (Installation, Testing & Removal)	Per Service	12	1	$45.29	$543
Personal Emergency Response System (Purchase, Rental, Repair)	Per Item	12	1	$215.40	$2,585

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Personal Emergency Response System (Response Center Service Fee)	Month	58	9	$33.98	$17,738
Respite Care (Client's Home)	Day	6	14	$60.19	$5,056
Respite Care (Room and Board Included)	Day	4	20	$146.98	$11,758
Respite Care (Routine)	Hour	6	70	$22.06	$9,265
Specialized Medical Equipment and Supplies	Per Item	233	4	$74.29	$69,238
Supportive Maintenance	Hour	12	50	$22.78	$13,668
Transportation - Non Medical (Per Mile)	Per Mile	12	1000	$0.39	$4,680
Transportation - Non Medical (Per One-Way Trip)	Per Trip	222	55	$15.85	$193,529
Transportation - Non Medical (Public Transit Pass)	Month	99	9	$89.14	$79,424
GRAND TOTAL:					$29,386,134
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1400
FACTOR D (Divide grand total by number of participants)					$20,990
AVERAGE LENGTH OF STAY ON THE WAIVER					273

State:	
Effective Date	

Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Adult Day Care	Day	2	120	$40.76	$9,782
Adult Residential Services (Assisted Living Facilities)	Day	992	273	$75.50	$20,446,608
Adult Residential Services (Certified Community Residential Care)	Day	175	200	$89.41	$3,129,350
Adult Residential Services (Licensed Community Residential Care)	Day	47	175	$111.77	$919,308
Assistive Technology Services	Per Item	7	1	$2,164.87	$15,154
Attendant Care Services	15 Minute	128	500	$3.27	$209,280
Caregiver Training	15 Minute	6	54	$5.28	$1,711
Case Management Service	15 Minute	1400	144	$21.65	$4,364,640
Chore Services	Per Service	7	10	$162.36	$11,365
Consumer Preparation Services	Hour	6	4	$60.10	$1,442
Environmental Accessibility Adaptations (Home Modifications)	Per service	6	1	$703.59	$4,222
Environmental Accessibility Adaptations (Vehicle modification)	Per service	6	1	$1,604.16	$9,625
Financial Management Services	Month	29	12	$51.96	$18,082
Habilitation Services	Hour	35	60	$24.51	$51,471
Home Delivered Meals	Per Meal	35	152	$6.35	$33,782
Homemaker Service	Hour	48	181	$16.77	$145,698
Institutional Transition Services	Per service	117	1	$530.60	$62,080
Medication Assistance Services (Medication Reminder System)	Month	6	5	$53.04	$1,591
Medication Assistance Services(Medication Set-up)	15 Minute	18	60	$21.39	$23,101
Personal Budget Assistance	15 Minute	292	66	$5.11	$98,480
Personal Emergency Response System (Installation, Testing & Removal)	Per Service	12	1	$46.20	$554
Personal Emergency Response System (Purchase, Rental, Repair)	Per Item	12	1	$219.71	$2,637

State:	
Effective Date	

Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Personal Emergency Response System (Response Center Service Fee)	Month	58	9	$34.66	$18,093
Respite Care (Client's Home)	Day	6	14	$61.39	$5,157
Respite Care (Room and Board Included)	Day	4	20	$149.92	$11,994
Respite Care (Routine)	Hour	6	70	$22.50	$9,450
Specialized Medical Equipment and Supplies	Per Item	233	4	$75.78	$70,627
Supportive Maintenance	Hour	12	50	$23.24	$13,944
Transportation - Non Medical (Per Mile)	Per Mile	12	1000	$0.40	$4,800
Transportation - Non Medical (Per One-Way Trip)	Per Trip	222	55	$16.17	$197,436
Transportation - Non Medical (Public Transit Pass)	Month	99	9	$90.92	$81,010
GRAND TOTAL:					$29,972,474
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1400
FACTOR D (Divide grand total by number of participants)					$21,409
AVERAGE LENGTH OF STAY ON THE WAIVER					273

State:	
Effective Date	

Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Adult Day Care	Day	2	120	$41.58	
Adult Residential Services (Assisted Living Facilities)	Day	992	273	$77.01	
Adult Residential Services (Certified Community Residential Care)	Day	175	200	$91.20	
Adult Residential Services (Licensed Community Residential Care)	Day	47	175	$114.01	
Assistive Technology Services	Per Item	7	1	$2,208.17	
Attendant Care Services	15 Minute	128	500	$3.34	
Caregiver Training	15 Minute	6	54	$5.39	
Case Management Service	15 Minute	1400	144	$22.08	
Chore Services	Per Service	7	10	$165.61	
Consumer Preparation Services	Hour	6	4	$61.30	
Environmental Accessibility Adaptations (Home Modifications)	Per service	6	1	$717.66	
Environmental Accessibility Adaptations (Vehicle modification)	Per service	6	1	$1,636.24	
Financial Management Services	Month	29	12	$53.00	
Habilitation Services	Hour	35	60	$25.00	
Home Delivered Meals	Per Meal	35	152	$6.48	
Homemaker Service	Hour	48	181	$17.11	
Institutional Transition Services	Per service	117	1	$541.21	
Medication Assistance Services (Medication Reminder System)	Month	6	5	$54.10	
Medication Assistance Services(Medication Set-up)	15 Minute	18	60	$21.82	
Personal Budget Assistance	15 Minute	292	66	$5.21	
Personal Emergency Response System (Installation, Testing & Removal)	Per Service	12	1	$47.12	
Personal Emergency Response System (Purchase, Rental, Repair)	Per Item	12	1	$224.10	

State:	
Effective Date	

Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Personal Emergency Response System (Response Center Service Fee)	Month	58	9	$35.35	
Respite Care (Client's Home)	Day	6	14	$62.62	
Respite Care (Room and Board Included)	Day	4	20	$152.92	
Respite Care (Routine)	Hour	6	70	$22.95	
Specialized Medical Equipment and Supplies	Per Item	233	4	$77.30	
Supportive Maintenance	Hour	12	50	$23.70	
Transportation - Non Medical (Per Mile)	Per Mile	12	1000	$0.41	
Transportation - Non Medical (Per One-Way Trip)	Per Trip	222	55	$16.49	
Transportation - Non Medical (Public Transit Pass)	Month	99	9	$92.74	
GRAND TOTAL:					$30,571,715
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1400
FACTOR D (Divide grand total by number of participants)					$21,837
AVERAGE LENGTH OF STAY ON THE WAIVER					273

State:	
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