Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Submitted by:

Utah Department of Health, Division of Medicaid and Health Financing

Submission Date:	**State Fiscal Year 2013 Amendment - Exact date to be determined**

CMS Receipt Date *(CMS Use)*	

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

1. Major Changes:

Changes as of the last Renewal (Approved July 1, 2009): This renewal application proposes several additional services. Some are entirely new, while others have been available as a component of a bundled service that has previously been available. The new services include Occupational Therapy, Speech Therapy, Cognitive Retraining, Physical Therapy, Environmental Adaptations, Specialized Medical Equipment and Supplies, and Living Start Up Costs. Previously bundled services which remain available in a now unbundled format include Behavior Consultation, Professional Medication Monitoring, Personal Budget Assistance, Residential Habilitation Services, Extended Living Supports, and Supported Living.

Additionally, changes in the HCBS Waiver Application have allowed the state to explain quality improvement strategies in much more detail in relation to Participant Direction of Services, Participant Rights, Participant Safeguards, and Systems Improvements.

The proposed new services and unbundling of other services have resulted in improvements to the current Waiver. Providing more detail about the quality management strategies will also work together with new and unbundled services to further enrich and enhance the operations of the Waiver.

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*): **Acquired Brain Injury**

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

O	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
O	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
X	**Renewal (5 Years) of Waiver #**	**0292.90.R2**	
O	**Amendment to Waiver #**		

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

O	**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.
X	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: **July 1, 2012**

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)*	
	O	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:
	O	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
X	Nursing Facility *(select applicable level of care)*	
	X	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:
	O	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:	

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:*			
X	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 purpose of the Utah Acquired Brain Injury Waiver is to offer services to individuals meeting the eligibility criteria of the waiver to meet their needs while living in a community setting of their choice.

The Department of Health, Division of Medicaid and Health Financing is the Administrative Agency for this waiver, while the Department of Human Services, Division of Services for People with Disabilities is the Operating Agency. The functions of the both of these agencies are specified in Appendix A of this application. DSPD utilizes an array of service providers in the community that comprise the direct service workforce for this population.

The ABI Waiver offers both the agency-based provider model, as well as the self-administered model as the service delivery methods.

Payment Process Work Plan
1. HIPAA Compliance - The Utah Departments of Health and Human Services will be conducting a review of HIPAA compliance with regard to HCBS Waiver claims. The SMA will submit a report back to CMS by September 30, 2009. The report will include an assessment of the state's compliance with HIPAA requirements for HCBS Waiver claims and a description of any changes or improvements that need to be made to the processes employed by the state.

2. Provider Mechanism to submit claims directly to MMIS - By August 1, 2009, DSPD will submit letters to all HCBS Waiver providers informing them of their option to bill Medicaid directly through the MMIS. The letter will include a schedule of multiple provider training sessions that will be available through the SMA to assure Waiver providers understand how to bill Medicaid directly. The provider training sessions will be held throughout the months of August and September. Any provider choosing to bill Medicaid directly will be allowed to begin the direct billing October 1, 2009. Provider contracts will be amended to exclude the requirement that providers reassign Medicaid payment to DHS. The signed contract amendments will be completed by December 31, 2009.

3. State Medicaid Agency internal controls for determining payment rates-
General Rate setting methodology:
Four different rate setting methodologies are available for use in setting rates. The four different methodologies are in place to accommodate the different market factors that exist for different types of services. DHS employs the rate setting methodology that best fits the circumstances of a particular service. For example, in this Waiver application, the state has added physical therapy, occupational therapy and speech therapy. Because DHS knows that similar services exist in the Medicaid State Plan, they proposed using the same payment rates used by the Medicaid State Plan. In this case, DHS employed the third methodology, "Comparative Analysis". Had the new services been ones that were not paid by Medicaid, but were commonly paid by other payers, then the fourth methodology, "Community Price Survey" may have been used. With all new services

and any inflationary increases or decreases to existing service rates, the SMA reviews and approves all proposed rates prior to the rates being loaded into the MMIS.

Rate review of existing services:
The SMA and DSPD will work together to compile all available historical information on currently existing service rates. The historical information will be reviewed by the SMA to determine if the information is sufficient to demonstrate that the rate is set appropriately. The SMA will submit a report to CMS by September 30, 2009 which describes the findings of the review. The report will also list any rates for which insufficient historical information is available to explain how the rate was originally set; the SMA will submit a schedule for reviewing these individual rates to assure the rates being paid are appropriate.

Review of the utilization of the term "Fiscal Agent":
The SMA and DSPD will work together to review the utilization of the term "fiscal agent". This will be resolved by either DSPD meeting the definition of fiscal agent at 42 CFR 434.10(d) or amending the contract.

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)*:

X	The waiver provides for participant direction of services. *Appendix E is required*.
O	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)*:

X	Yes
O	No
O	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)*
X	**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 and the Division of Services for People with Disabilities completed the initial draft application August, 2008. The Agencies convened a work group consisting of consumers, advocates, providers and state agency representatives to review the initial draft application. Four workgroup meetings where completed during August and September 2008. Amendments to the draft were completed October 2008. The revised draft was submitted to a broad network of consumers, advocates, providers and Tribal Governments and the Medical Care Advisory Committee (MCAC). The entities had 30 days in which to submit comments or questions about the ABI Waiver Application.

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:	Department of Health, Division of Medicaid and Health Financing
Address 1:	288 N. 1460 W.
Address 2:	
City	Salt Lake City
State	Utah
Zip Code	84114
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:	Paul
Last Name	Smith
Title:	Division Director
Agency:	Department of Human Services, Division of Services for People with Disabilities
Address 1:	195 N. 1950 W.
Address 2	
City	Salt Lake City
State	Utah
Zip Code	84116
Telephone:	801-538-8299
E-mail	ptsmith@utah.gov

Fax Number	801-538-4279

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: __/s/Michael Hales_____ ____
State Medicaid Director or Designee

Date:	**November 2, 2012**

First Name:	Michael
Last Name	Hales
Title:	Division Director
Agency:	Department of Health, Division of Medicaid and Health Financing
Address 1:	288 N. 1460 W.
Address 2:	
City	Salt Lake City
State	Utah
Zip Code	84114
Telephone:	801-538-6965
E-mail	mthales@utah.gov
Fax Number	801-538-6860

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*):	
	○	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):*	
X	The waiver is operated by **The Division of Services for People with Disabilities** 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:

An interagency agreement between the State Medicaid Agency (SMA) and the Division of Services for People with Disabilities (DSPD) sets forth the respective responsibilities for the administration and operation of this waiver. This agreement runs for five year periods, but can be amended as needed.

The agreement delineates the SMA's overall responsibility to provide management and oversight of the waiver, as well as DSPD's operational and administrative functions.

The responsibilities of the Operating Agency are delegated as follows. Most of the responsibilities are shared with the SMA:

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

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

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (s*elect 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.*
X	**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*:
X	**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	X	X	☐	☐
Waiver enrollment managed against approved limits	X	X	☐	☐
Waiver expenditures managed against approved levels	X	X	☐	☐
Level of care evaluation	X	X	☐	☐
Review of Participant service plans	X	X	☐	☐
Prior authorization of waiver services	X	X	☐	☐
Utilization management	X	X	☐	☐
Qualified provider enrollment	X	X	☐	☐
Execution of Medicaid provider agreements	X	☐	☐	☐
Establishment of a statewide rate methodology	X	☐	☐	☐
Rules, policies, procedures and information development governing the waiver program	X	X	☐	☐
Quality assurance and quality improvement activities	X	X	☐	☐

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 DSPD 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 • **Quarterly meeting minutes** • **Correspondences (email, letters etc.)** • **Topic specific meeting minutes**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	X *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*

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

Performance Measure: #2	**DSPD 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** • **DSPD 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)*
	X *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	X *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation	***Responsible Party for***	***Frequency of data***	

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

Performance Measure: **#3**	**The SMA approves maximum allowable rates (MARs) for covered Waiver services.**		
Data Source • **Rate setting meetings minutes** • **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)*
	X *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	X *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X *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*	
	X *State Medicaid*	☐ *Weekly*	

	Agency		
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure: #4	**Disenrollment. Prior to involuntary disenrollment from the Waiver DSPD explores all reasonable alternatives and the Disenrollment Protocol has been completed. Final authority for involuntary disenrollment resides with the SMA.**		
Data Source • **Disenrollment documents** • **Correspondence between the SMA and DSPD**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X *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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	

	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

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

		X *Other: Specify: At a minimum every two years.*	

Performance Measure: #6	**DSPD will prepare and submit an annual incident report which includes an analysis of incident data and remediation or quality improvement strategies that address the analysis.**		
Data Source • **Participant records** • **Form 1-8**	***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*	**X** *100% Review*
	X *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X *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*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure: #7	**DSPD will provide the SMA a copy all quality assurance activities reports which will include an analysis of findings, remediation and**

	quality improvement activities.		
Data Source • **DSPD annual 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*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify: At a minimum every two 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*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify: At a minimum every two years.*	

Performance Measure: **#8**	**DSPD notifies the SMA of critical incidents and events and submits findings of investigations as per SMA protocol.**		
Data Source • **Critical Incident/Event Findings Operating**	***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)*

Agency Report to SMA			
	X *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	X *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X *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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *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 ABI waiver program through numerous activities including the issuance of policies, rules, and regulations relating to the waiver, the approval of all protocols, documents and trainings that affect any aspect of the ABI waiver operations. Approvals are accomplished through a formal document approval process. The SMA also conducts quarterly meetings with DSPD (the operating agency), monitors compliance with the Interagency Agreement, receives and reviews quarterly ABI Waiver Reports from DSPD, and provides technical assistance to the operating agency and other entities within the state that affect the operation of the waiver program. The SMA conducts an annual review of the ABI 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 DSPD and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5. The SMA is the entity responsible for official

communication with CMS for all issues related to the ABI 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 DSPD and the SMA 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)*
	X *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	**X** *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)*
X	**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
X	**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)			
		☐	Disabled (Other) (under age 65)			
	X	**Specific Recognized Subgroups** *(check each that applies)*				
		X	Brain Injury	18		X
		☐	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:

Waiver services are limited to individuals with the following disease(s) or condition(s)

1. Acquired brain injury is defined as being injury related and neurological in nature, and may include cerebral vascular accident and brain injuries that have occurred after birth. Acquired brain injury does not include individuals whose functional limitations are due solely to mental illness, substance abuse, personality disorder, hearing impairment, visual impairment, learning disabilities, behavior disorders, aging process, or individuals with deteriorating diseases such as multiple sclerosis, muscular dystrophy, Huntington's chorea, ataxia, or cancer.

2. Individuals must meet a qualifying ICD 9 CM diagnoses as outlined in Administrative Rule: R539-1-8 (1)(a).

3. Individual must score between 40 and 120 on the Comprehensive Brain Injury

Assessment (CBIA) Form as outlined in Administrative Rule :R539-1-8 (1)(c).

4. This waiver is not available to individuals who have suffered congenital brain injury, or brain injuries induced by birth trauma.

5. This waiver is limited to persons with disabilities who have established eligibility for State matching funds through the Utah Department of Human Services in accordance with UCA 62A-5.

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

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)*:

X	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*):

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:

X	**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	198
Year 2	198
Year 3	198
Year 4 (renewal only)	198
Year 5 (renewal only)	198

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)*:

X	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)*:

X	**Not applicable**. The state does not reserve capacity.
O	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):*

X	The waiver is not subject to a phase-in or a phase-out schedule.
O	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:*

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

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

Medicaid recipients who meet the programmatic eligibility requirements as defined in Appendix B-1 are given a choice (in writing) to either receive services to meet the identified

needs in a Nursing Facility (NF), or through the Acquired Brain Injury Waiver. If the individual chooses to receive services through the Waiver, available capacity is determined.

If available capacity exists, the individual is enrolled in the Waiver.

If available capacity does not exist, the applicant will be advised in writing that he or she may access services through a NF or may wait for available capacity in the Acquired Brain Injury Waiver.

If the individual chooses to wait for available capacity, the operating agency provides information about community resources to assist the individual in the interim. If the individual is not a Medicaid recipient at the time of application, information will be given on applying for Medicaid.

In all cases, the applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the individual record.

As directed by State law, the DSPD has established a Critical Needs Assessment process by which individuals are ranked on a waiting list to prioritize access to Waiver services. A significant component of the Critical Needs Assessment tool addresses the immediacy of the need for services and the individual's risk in not gaining access to Waiver services. The applicant is placed on a waiting list according to their critical need ranking. The waiting list includes applicants who are seeking to receive Waiver services through DSPD and is not waiver specific.

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
X	SSI Criteria State
○	209(b) State

a-2. Miller Trust State.

Indicate whether the State is a Miller Trust State.

○	Yes
X	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)			
X	Low income families with children as provided in §1931 of the Act		
X	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
X	Optional State supplement recipients		
X	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	X	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL
X	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)		
X	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		
X	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*:		

	42 CFR 435.301, 435.308, 435.310, 435.113 1902(a)(10)(A)(i)(III) and 1905(n) 1902(a)(10)(A)(i)(IV) and 1902(1)(1)(A) and 1902(1)(1)(A) and (B) 1902(a)(10)(A)(i)(VII) and 1902(1)(1)(D) 1902(e)(5), 1902(e)(6) 1902(a)(10)(A)(ii)(XVII)

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.
X	**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		
	X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:		
		X	A special income level equal to (select one):	
			X	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)*:

X	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*):	
	X	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):		

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○	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*):

○	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)*				

○	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.	
X	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 and 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 dependent family members live in a community setting, the State will recognize that expenses may be higher due to the waiver client incurring additional costs related to supporting the dependent family members. An allowance may be deducted when making the eligibility determination in consideration of these additional expenses. This additional allowance is the difference between the allowance for a family member defined in Section 1924(d)(1)(C) of the Social Security Act and the allowance for a family member defined in 42 CFR Section 435.726(c)(3).			
○	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.
	○	The amount is determined using the following formula:		
X	Not applicable *(see instructions)*			

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

○	AFDC need standard		
X	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.
X	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
X	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 and 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		
X	Allowance is different. Explanation of difference:		
	We added an 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 a family member defined in Section 1924(d)(1)(C) of the Social Security Act and the allowance for a family member defined in 42 CFR 435.726(c)(3).		
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.		
X	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)*:	
	X	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
X	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
○	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:

Acquired Brain Injury Support Coordinator (ABISC) - Certified by DSPD

Qualified support coordinators shall possess at least a Bachelors degree in nursing, behavioral science, or a human services related field such as social work, sociology, special education, rehabilitation counseling, or psychology and demonstrate competency relating to the planning and delivery of health services to the Acquired Brain Injury population through successful completion of a training and testing program approved by the State Medicaid Agency.

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

Utah Administrative Rule 414-502 defines the State's level of care for nursing facility care. The rule defines that a client must meet two of the following three criteria:

(1) Due to the diagnosed medical conditions, the applicant requires at least substantial physical assistance with activities of daily living above the level of verbal prompting, supervising, or setting up;

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

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

The tool used to make this determination is the Comprehensive Brain Injury Assessment (CBIA). The applicant must score between 40 - 120 on this assessment.

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.
X	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 primary instrument used to determine level of care in nursing facilities is the Minimum Data Set (MDS) assessment. Because this assessment was designed to determine the needs of individuals residing in facility based settings, the state utilizes a tool that assesses the same elements, but that is geared toward assessing a person's needs and abilities in a community based setting. The Comprehensive Brain Injury Assessment (CBIA) 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. It contains a thorough assessment of the individual's diagnostic and other health considerations, the individual's ability to complete activities of daily living and instrumental activities of daily living, and to assess additional services needed.

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:

The Form 817b is the form that documents that the individual meets the level of care criteria and other program eligibility requirements. This form is completed when evaluating applicants for their need for the level of care under the Waiver. The Comprehensive Brain Injury Assessment (CBIA) is the assessment tool used to assess the applicant, including this individual's diagnoses, ADL, IADL, medical and social needs. The CBIA is completed at the initial level of care evaluation, as well as each year for the reevaluation.

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)*:

O	Every three months
O	Every six months
O	Every twelve months
X	Other schedule (*specify*):
	Every 12 months or more often as needed

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

X	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
O	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 Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS), developed and maintained by the Division of Services for People with Disabilities, provides from an automated tickler "to do" message to be sent to the support coordinator at the beginning of the month in which a re-evaluation is due.

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:

Electronically retrievable documentation of all evaluations and re-evaluations are maintained within the USTEPS system. To assure documents are retrievable, standard data back-up procedures employed with the UTSTEPS datebase include: The DSPD_USTEPS_PROD_DB is backed up from Sybase database to a disk dump at 10:30 PM every night. The UNIX backup occur on the following schedule (these are backups to tape)

Monthly Full on 1st of each month – copies are retained on and off site for 3 years

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**	**A level of care is conducted for all participants who meet DSPD service criteria and request to be served by the ABI Waiver**		
Data Source • **DSPD 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*	**X** *100% Review*
	X *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *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***	

State:	
Effective Date	

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

Performance Measure: #2	**Participants who are admitted to the ABI Waiver meet nursing facility level of care.**		
Data Source • **Participant records** • **CBIA** • **Form 817b**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* *OA: At a minimum every two years.* *SMA: At a minimum every five years.*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis***	***Frequency of data aggregation and analysis:***	

State:	
Effective Date	

	(check each that applies	*(check each that applies*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *OA: At a minimum every two years.* *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**	**Level of Care is reviewed at least annually.**		
Data Source • **Participant Records** • **CBIA** • **817b**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	

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

Performance Measure: #2	**Participant's level of care is re-evaluated whenever a substantial change in health status occurs to determine if the change constitutes continued nursing facility level of care.**		
Data Source • **Participant records** • **CBIA** • **Participant interviews**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence*

			Interval = 5
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify: OA: At a minimum every two years. SMA: At a minimum every five years.*	
			☐ *Other: Describe* DSPD:
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify: OA: At a minimum every two years. 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).

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**	**A qualified ABI support coordinator performs initial evaluations and re-evaluations of Level of Care.**		
Data Source • **Participant records** • **DSPD 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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify: 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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify: At a minimum every five years.*	

***Performance Measure:* #2**	**Level of care is documented on form 817b.**

State:	
Effective Date	

Data Source • **Participant records** • **Form 817b**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* *OA: At a minimum every two years.* *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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *OA: At a minimum every two years.* *SMA: At a minimum every five years.*	

Performance Measure: **#3**	**Form 927 "Home and Community-Based Waiver Referral Form" is used to document the effective date of the applicant's Medicaid**

State:	
Effective Date	

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

Individuals who request services from DSPD are screened for level of care for all waivers, ranked according to critical needs assessment process and placed on the waiting list. When the individual is taken off the waiting list, the ABI Support Coordinator/Intake Worker (ABISC) determines if the individual needs services from the ABI Waiver. For all individuals who have been taken off the waiting list and continue to require services, an initial evaluation for level of care is conducted by the ABISC. The SMA conducts an annual review of the ABI 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 DSPD and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

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 DSPD 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)*
	X *State Medicaid Agency*	☐ *Weekly*
	X *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*

		X *Other: Specify:* *OA: At a minimum every two years.* *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)*
X	**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.

Appendix B-7: Freedom of Choice

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

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Freedom of Choice is documented on the Form 818b.

Freedom of choice procedures:

1. When an individual is determined eligible for waiver services, the individual and the individual's legal representative, if applicable, will be informed of the alternatives available under the waiver and offered the choice of institutional care (NF) or home and community-based care. A copy of the DSPD publication *AN INTRODUCTORY GUIDE—Division of Services for People with Disabilities* (hereafter referred to as the Guide), which describes the array of services and supports available in Utah including nursing facilities and the HCBS Waiver program, is given to each individual applying for waiver services.

2. The support coordinator will offer the choice of waiver services only if:
   a. The individual's needs assessment indicates the services the individual requires, including waiver services, are available in the community.
   b. The individual support plan has been agreed to by all parties.
   c. The health and safety of the individual can be adequately protected in relation to the delivery of waiver services and supports.

3. Once the individual has chosen home and community-based waiver services, the choice has been documented by the support coordinator, and the individual has received a copy of the Guide, subsequent review of choice of program will only be required at the time a substantial change in the enrollee's condition results in a change in the individual support plan. It is, however, the individual's option to choose institutional (NF) care at any time during the period they are in the waiver.

4. The waiver enrollee, and the individual's legal representative if applicable, will be given the opportunity to choose the providers of waiver services identified on the individual support plan if more than one qualified provider is available to render the services. The individual's choice of providers will be documented in the individual's support plan.

5. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to the institutional care specified for this request, or who are denied the waiver service(s) of their choice or the waiver provider(s) of their 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.

The Freedom of Choice form, 818b, is maintained by the individual support coordinator in hard copy format.

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

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

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

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

For the full text of the Medicaid Member Guide, go to:

http://health.utah.gov/umb/forms/pdf/mg_w_cover.pdf

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

Other Services *(select one)*	
○	Not applicable
X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Environmental Adaptations
b.	Transportation Services (non-medical)

c.	Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee
d.	Specialized Medical Equipment/Supplies/Assistive Technology-Purchase
e.	Personal Emergency Response System
f.	Living Start-Up Costs
g.	Chore Services
h.	Companion Services
i.	Behavior Consultation I, II & III
j.	Extended Living Supports
k.	Personal Budget Assistance
l.	Professional Medication Monitoring
m.	Supported Living
n.	Cognitive Retraining

Extended State Plan Services *(select one)*

○	Not applicable
X	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	Speech Therapy
b.	Physical Therapy
c.	Occupational Therapy

Supports for Participant Direction *(check each that applies))*

X	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	X	Consumer Preparation Services
Financial Management Services	X	

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)*:

X	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:

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)*:

X	**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):
	UCA 62A-2-120 and R501-14 of the Utah Human Services Administration requires all persons having direct access to children or vulnerable adults must undergo a criminal history/ background investigation except in the case where the waiver enrollee has chosen to self-employ a family member as part of their self directed program. If the person has lived in Utah continuously for 5 years or more a regional check is conducted. For those not having lived in Utah for 5 continuous years a national check through the FBI is conducted. The Office of Licensing, an agency within the Utah Department of Human Services has the responsibility of conducting background checks on all direct care workers who provide waiver services. The scope of the investigation includes a check of the State's child and adult abuse registries, and a Criminal History check through the Criminal Investigations and Technical Services Division of the Department of Public Safety. If a person has lived within two to five years outside the State of Utah or in foreign countries the FBI National Criminal History Records and National Criminal History will be accessed to conduct a check in those states and countries where the person resided. For providers under the Self Administered Service Model, the state will withhold payments for services for anyone who has not completed a background check. DSPD keeps a database on all approved employees. All employees must annually renew these checks. A client has the option of having a criminal background check completed on a family member if they chose to do that, but it is not required. The health and safety of clients are ensured by routinely scheduled face-to-face visits by support coordinators, and by quality monitoring reviews by both the operating agency and the SMA.
○	**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)*:

X	**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):
	UCA 62A-2-121, 122 and R501-14 of the Utah Human Services Administration requires all persons having direct access to children or vulnerable adults must undergo an abuse screening except in the case where the waiver enrollee has chosen to self-employ a family member as part of their self directed program. The Utah Division of Aging and Adult Services and The Utah Division of Child and Family Services maintain these abuse registries. A designated staff person within DHS, Office of Licensing, completes all screenings. DSPD maintains a database on all approved employees. DSPD will not approve payments if the required screenings have not been completed.
○	**No**. The State does not conduct abuse registry screening.

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

X	**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

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.

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	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:*

X	**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.*
X	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.*

	As per Administrative Rule R539-5-5 Parents, step-parents, legal guardians and spouses are not permitted to provide waiver services. Relatives, other than those listed above, may provide specified waiver services. The same payment controls are employed as described in Appendix E-1:1. Relatives may not provide services to multiple participants at the same time, but relatives may provide more than one service to a participant with the limitation that the services may not be provided at the same time. For example, a relative may be a provider of both personal care and respite services, but they would not be eligible to bill for both services concurrently. Since parents, step parents, legal guardians and spouses are not permitted to provide Waiver services, the State avoids the problem of having those with decision making authority also providing services. For Relatives: Support Coordinators conduct monthly reviews of all services provided before claims are paid. Support Coordinators monitor the use of services as defined in the Care Plan. DSPD conducts random sample audits each year on the SAS programs that focus on service usage and interviews with clients and employees about service utilization. DSPD monitors service utilization each month and notifies the contract monitoring units if there is any indication of fraud or abuse of funds - for more in-depth audits to be completed.
○	Other policy. *Specify*:

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 Utah Department of Health will enter into a provider agreement with all willing providers who are selected by recipients and meet licensure, certification, competency requirements and all other provider qualifications.

The Utah Department of Human Services in conjunction with the Bureau of Contract Management will issue an Invitation to submit Offer (ISO) for the purpose of entering into a contract with willing and qualified individuals and public or private non-profit organizations.

The ISO is posted on the Department of Human Services website and remains open, allowing for continuous recruitment. The request includes service requirements and expectations. A review committee evaluates the proposals against the criteria contained in the ISO and selects those who meet the qualifications.

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**	**Providers meet DSPD provider contract criteria.**		
Data Source • **Provider 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)*

• **Provider staff interviews**			
	☐ *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	X *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X *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*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

***Performance Measure:* #2**	**Providers have an adequate quality management plan and human rights plan.**		
Data Source • **Provider Quality management plan** • **Provider Human Rights Plan** • **Provider 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)*

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

***Performance Measure:* #3**	**Provider sites are safe and in good repair.**		
Data Source • **SMA Provider Site Review Checklist (physical review, health and safety review)** • **DSPD contract analyst**	***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)*

Certification Checklist • **DHS Office of Licensing Residential Support Rules Checklist**			
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	X *Other: Specify:* *DHS Office of Licensing*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* *OA and DHS Office of Licensing: Annually.* *SMA: At a minimum every 5 years.*	
			X *Other: Describe* *OA and DHS Office of Licensing: 100% Review.* *SMA: Less than 100% Review.*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *OA: Annually.* *SMA: At a minimum every 5 years.*	

State:	
Effective Date	

Performance Measure: #4	**Licensed health care providers that render services to waiver participants maintain substantial compliance with State and Federal Regulations.**		
Data Source • **Bureau of Licensing 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*	**X** *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	X *Other: Specify: DOH Bureau of Licensing*	☐ *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify: At a minimum every two 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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	X *Other: Specify: DOH Bureau of Licensing*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

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**	**Self-Administered Services (SAS) providers meet all Waiver requirements including accurate and updated employee files, completion of appropriate forms, appropriate training and proper billing for services.**		
Data Source • **Billing data** • **Employee Files** • **PCSP** • **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*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	**X** *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*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	

		☐ *Continuously and Ongoing*	
		X *Other: Specify: At a minimum every two years.*	

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**	**Provider staff completed all required training.**		
Data Source • **Provider records** • **Provider Interviews**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	X *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other*	
			☐ *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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

***Performance Measure:* #2**	**Provider staff are able to describe participant goals and progress.**		
Data Source • **Provider Interviews** • **Participant service plans**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* *At a minimum every 5 years.*	
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	

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	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *At a minimum every five years.*	

***Performance Measure:* #3**	**Provider staff are trained regarding implementation of behavior strategies.**		
Data Source • **Provider Interviews** • **Behavior Support Plans**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and*	

		Ongoing	
		X *Other: Specify:* *At a minimum every five years.*	

Performance Measure: #4	**Provider staff can articulate behavior support plan strategies.**		
Data Source • **Provider Interviews** • **Behavior Support Plans**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify: At a minimum every 5 years.*	
			☐ *Other:*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *At a minimum every five years (SMA).*	

***Performance Measure:* #5**	**ABI Support Coordinators completed all required training.**		
Data Source • **DSPD Support Coordinator 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*	**X** *100% Review*
	X *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X *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*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *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 conducts provider site reviews at a minimum every five years. The SMA reviews provider sites to assure that they are safe and in good repair. The SMA also interviews direct care staff to determine if they have knowledge of participant goals and can describe progress that is made on each goal. In addition provider staff are interviewed to determine if they

received training on a participant's behavior support plan and if they are knowledgeable of problem behaviors and strategies to decrease problem behaviors. DSPD contract analysts conduct annual provider reviews of all programs that provide services to ABI Waiver participants. Monitoring includes all criteria specified in the provider contract. The DSPD Quality Management Team conducts Quality Improvement provider reviews. The reviews consist of an assessment of quality improvement practices, human rights, grievances and participant choice. Support coordinators monitor provider staff to assure that staff are able to describe participant goals and progress on the goals. Support coordinators also monitor a sample of SAS employees on a monthly basis. The support coordinators complete a review checklist, which covers employee files, forms, and appropriate training for staff. Time sheets are reviewed to ensure proper billing for services. In most cases, support coordinators meet in person with employees to confirm proper training and work hours. Providers of services for the ABI Waiver must complete all required training as specified in the State Implementation Plan. The USTEPS system tracks the expenditures for each participant and ensures that services remain within the allotted budget. DSPD Region contract analysts conduct monitoring as part of the annual Provider Contract Review to verify that the provider has a system to document in employee records required training and competency. The SMA conducts an annual review of the ABI 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 DSPD and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

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 DSPD 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	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that*

identification)		*applies)*
	X *State Medicaid Agency*	☐ *Weekly*
	X *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		X *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)*
X	**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:	
Effective Date	

3.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:	**ABI Waiver Support Coordination**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	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)**:**

ABI Waiver Support Coordination serves the purpose of: (a) establishing and maintaining the individual in the support system and the Home and Community-Based Services Waiver in accordance with program requirements and the individual's assessed support needs and (b) coordinating the delivery of quality waiver services.

Support Coordination assists individuals to: (a) establish Medicaid financial and categorical eligibility, (b) identify the supports necessary to insure the individual's health and safety, (c) write, coordinate, integrate, and assure the implementation of the individual's support plan, (d) gain access to waiver supports, State Plan services, medical, social, and educational assessments and services, and any other services, regardless of the funding source, and (e) develop a personal budget as a component of the individual support plan.

Support Coordination also involves activities to: (f) provide an initial assessment and ongoing reassessment of the individual's level of care determination, (g) facilitate a person-centered plan, (h) review the individual's support plan at such intervals as are specified in the Waiver Application document, (i) write and update personal social history, (j) provide ongoing monitoring to assure the provision and quality of the supports identified in the individual's support plan, (k) instruct the individual/legal representative/family how to independently obtain access to services and supports, regardless of funding source, (l) provide discharge planning services up to 90 days immediately prior to the date an individual living in a Nursing Facility is transitioned to the waiver, and (m) provide discharge planning services up to 90 days immediately prior to the date an individual is dis-enrolled from the waiver.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**		Individual. List types:	X	Agency. List the types of agencies:
				Individual Medicaid Provider
Specify whether the service may be	☐	Legally Responsible Person	☐	Relative/Legal Guardian

State:	
Effective Date	

provided by *(check each that applies):*				

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency Based—Individual Medicaid Provider		Certified by DSPD as an Acquired Brain Injury Support Coordinator (ABISC). The ABISC certification process is an internal process offered through DSPD.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Qualified support coordinators shall possess at least a Bachelors degree in nursing, behavioral science or a human services related field such as social work, sociology, special education, rehabilitation counseling, or psychology and demonstrate competency relating to the planning and delivery of health services to the Acquired Brain Injury population through successful completion of a training and testing program approved by the State Medicaid Agency, leading towards certification of an Acquired Brain Injury Support Coordinator (ABISC). The certification process is an internal process offered through DSPD.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Medicaid Provider	Division of Services for People with Disabilities ABI Support Coordinators are monitored and evaluated on an ongoing basis by: A) their DSPD Supervisors, B) the ABI Program Manager, and C) by the internally operated DSPD quality enhancement team	Annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	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.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Homemaker Services consist of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for those activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Limitations: These services will be provided only in the case where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. Homemaker Services are not available to individuals receiving other waiver services in which the services are essentially duplicative of the tasks defined in Homemaker Services. This service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Self-directed services provider		Homemaking Provider	

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

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Self-directed -- Homemaker		Certified by DSPD as an authorized provider of services and supports to people	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA and R539-5.

State:	
Effective Date	

		with disabilities in accordance with 62A-5-103, UCA.	Completed Provider Agreement
Agency Based--Homemaker	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Homemaker Services	Division of Services for People with Disabilities	Annually

Service Delivery Method

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

Service Specification

Service Title:	**Residential Habilitation**

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.
X	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Residential Habilitation means individually tailored supports that assist with acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision.

Residential Habilitation Settings:

- Group Homes – Licensed facilities in which 4 or more individuals reside
- Supervised Private Residences – Individual supervised apartments or home settings in which 3 individuals or less reside
- Professional Parent Homes – Supervised Private Residences for 2 or less individuals ages 18 - 22.
- Host Homes – Supervised Private Residences for 2 or less individuals aged 22 or older.

Daily services/rates are rendered for 18 hours during the week when in school or at work and for 24 hours during the weekend or holidays.

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

Limitations: Payment is not made for the cost of room and board, the cost of building maintenance, upkeep and improvement, or to meet the requirements of the applicable life safety code. Payment is not made, directly or indirectly, to members of the individual's immediate family. Payment for this service is also unavailable to those who are simultaneously receiving any other services within this waiver that would be duplicative or overlapping in nature of the services contained within this service definition.

This service is available to all Waiver participants including individuals in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services. For individuals aged 18-22, in the custody of the Division of Child and Family Services, the costs of basic and routine support and supervision are not covered as waiver services. Compensation for this routine support and supervision are covered by other funding sources associated with the Division of Child and Family Services. Individuals in DCFS custody are eligible to receive this service only after the provision of this service has been prior-authorized by the individual's support coordinator. Such prior-authorization will occur only after it has been determined that the individual has exceptional care needs that materially affect the intensity or skill level required of the service provider. Evidence that an individual in custody has such exceptional care needs include any one of the following: emotional or behavioral needs such as hyperactivity; chronic depression or withdrawal; bizarre or severely disturbed behavior; significant acting out behaviors; persistent attempts at elopement; habitual alcohol or drug use; sexually promiscuous behavior; sexual perpetration; persistent injurious or destructive behaviors; severe eating disorders including anorexia nervosa, pica or polydipsia; the presence of psychotic or delusional thinking and behaviors; or, the individual otherwise demonstrates the need for 24-hour awake supervision or care in order to ensure the safety of the individual and those around him/her. Additionally, individuals in custody of the State of Utah: Department of Human Services, Division of Child and Family Services may only receive this service if they demonstrate medical or personal care needs of an exceptional nature including any one of the following: requiring catheterization or ostomy care; requiring tube or gavage feeding or requires supervision during feeding to prevent complications such as choking, aspiration or excess intake; requires frequent care to prevent or remedy serious skin ailments such as pressure sores or persistent wounds; requires suctioning; requires assistance in transferring and positioning throughout the day; require two or more hours of therapy follow-through per day; requires assistance with multiple personal care needs including dressing, bathing and toileting; requires complex medical, medication or treatment follow-through throughout the day; or, the individual has a complex and unstable medical condition that requires constant and direct supervision.

This service is intended to accomplish a clearly defined set of outcomes associated with the individual's habilitation that is outlined in their individual support plan. Services provided under this

service definition are only those that are over and above the basic routine supports provided for through the Division of Child and Family Services.

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

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)*
Residential Habilitation Services	R501-2 UAC, R539-6 UAC (4 or more individuals)	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Residential Habilitation Provider	Division of Services for People with Disabilities	Annually

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

Service Specification	
Service Title:	**Day Supports**
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.
X	Service is included in approved waiver. The service specifications have been modified.

○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Day Supports provides assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that typically takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services are most commonly provided in licensed day-training or other habilitative facilities, or in integrated community settings with individuals without disabilities (not including staff paid to support the person). Services shall normally be furnished on routine workdays on a regularly scheduled basis.
Day supports shall focus on enabling the individual to attain or maintain his or her maximum functional level. The nature of the Day Supports services offered to each individual is based upon an assessment of the needs of the individual at the time and may change over time.

Elements of Day Supports:
Site Based Day Supports - services provided in a licensed setting in which 4 or more individuals attend.
Non-Site Based Day Supports - designed to take place in the community and are driven by the individual's preferences.
Senior Supports - designed for individuals who have needs that closely resemble those of older persons who desire a lifestyle consistent with that of the community's population of similar age or circumstances. The support is intended to facilitate independence, promote community inclusion and prevent isolation.

Daily services/rates are rendered for average of six hours per day.

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

Limitations: Individuals receiving Day Supports are not eligible to receive separate, individual waiver services in addition to this service if the separate service is essentially duplicative of the tasks defined in Day Supports. Individuals receiving Day Supports services may not receive the Extended Living service simultaneously. This service is not available to individuals eligible to receive this service through the Medicaid State Plan or other funding source.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Day Supports provider

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)*
Day Supports Provider	Site based: R501-2, UAC R539-6, UAC	Certified by DSPD as an authorized provider of	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

	R539-7, UAC (4 or more individuals)	services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Day Supports Provider	Division of Services for People with Disabilities	Annually

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

Service Specification	
Service Title:	**Supported Employment**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	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)**:**

Supported Employment serves the purpose of supporting individuals, based on individual need, to obtain, maintain, or advance in competitive employment in integrated work settings.

Supported Employment can be full or part time and occurs in a work setting where the individual works with individuals without disabilities (not including staff or contracted co-workers paid to support the individual). Supported Employment may occur anytime during a twenty-four hour day and supports are made available in such a way as to assist the individual to achieve competitive employment (compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities). Individuals in Supported Employment are supported and employed consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual as indicated in the individual's support plan. An individual may be supported individually or in a group. Supported Employment may also include activities and supports designed to assist individuals who are interested in creating and maintaining their own business enterprises.

Elements of Supported Employment Services:

Supported Employment Co-Worker Services – provider contracts with a co-worker to provide additional support under the direction of a job coach as a natural extension of the workday.

Supported Employment Enclave/Mobile Work Crew- A small crew of waiver participants, or enclave are trained and supervised amongst employees without disabilities at the host company's worksite, or the crew may operate a self-contained business that operates at multiple locations within the community, under the supervision of a job coach.

Supported Employment – Customized Employment – Individuals desiring to create and implement their own business enterprises receive training, instruction and coaching from a provider in such topics as: creating a business plan, conducting a market analysis, obtaining business financing, implementing the business and managing financial accounts.

Daily services/rates are rendered for six hours or more per day.

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

Limitations: Payment will only be made for adaptations, supervision and training required by an individual as a result of the individual's disability and will not include payment for the supervisory activities rendered as a normal part of the business setting. Documentation will be maintained that supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Act. Federal Financial Participation will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as incentive payments made to an employer or beneficiaries to encourage or subsidize an employer's participation in a supported employment program, payments that are passed through to a beneficiary of Supported Employment programs, or for payments for vocational training that is not directly related to a beneficiary's Supported Employment program.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Supported Employment Provider

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)*
Supported Employment Provider	Current Business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Supported Employment Provider	Division of Services for People with Disabilities	Annually

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

Service Specification	
Service Title:	Respite
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.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Respite care is provided to give relief to, or during the absence of, the normal care giver. Routine 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.

Daily services/rates are rendered for six hours or more per day.

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

Limitations: 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 are rendered out of the consumer's private residence in a setting approved by the State for a period of six hours or more, this service will be billed under a specific "Respite Care-Out of the home/Room and Board included" billing code.

In the case of services contained within this definition provided in the provider's or the consumer's home, in no case will more than four (4) individuals be served by the provider at any one time, except that the provider's children over the age of 14 will not be counted toward the limit of four. In the case of services included in this definition provided by a facility-based program, no more than twenty (20) individuals will be served by the provider at any one time, conditioned upon the stipulation that the provider deploys sufficient staff to meet staff to client ratios approved by the DSPD Regional Director of the appropriate region in advance and further, that staff to client ratios maintained by providers of this service fully conform to all relevant specifications in applicable licensing statutes or administrative

rule. Individuals receiving services within the Day Supports or Supported Living services may receive Respite Care-Routine services only on an hourly and not a daily basis and only during times that they are not receiving Day Supports or Supported Living services.

This service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services.

This service is not for ongoing daycare nor is this service intended to supplant resources otherwise available for child-care.

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Self-directed services provider		Respite Provider	

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

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Self-directed—Respite		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA and R539-5. Completed Provider Agreement
Agency based--Respite	Licensed by the State of Utah as a specific category of facility/agency as follows: Licensed Residential Treatment Programs R501-19, UAC Licensed Residential Support Programs R501-22, UAC	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider

	Nursing Facility: R432-150, UAC Assisted Living Facility: R432-270, UAC		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Respite Provider	Division of Services for People with Disabilities	Annually

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

Service Specification	
Service Title:	**Environmental Adaptations - Home**
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.
X	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Environmental Adaptations for the home involve equipment and/or physical adaptations to the individual's residence that are necessary to assure the health, welfare and safety of the individual or enhance the individual's level of independence. The equipment/adaptations are identified in the individual's support plan and a qualified professional specifies the model and type of equipment. The adaptations may include purchase, installation, and repairs. Such equipment/adaptations include:

a. Ramps
b. Lifts/elevators
    1. Porch or stair lifts
    2. Hydraulic, manual or other electronic lifts
c. Modifications/additions of bathroom facilities
    1. Roll-in showers
    2. Sink modifications
    3. Bathtub modifications/grab bars
    4. Toilet modifications/grab bars
    5. Water faucet controls
    6. Floor urinal and bidet adaptations and plumbing modifications

7. Turnaround space adaptations

d. Widening of doorways/hallways

e. Specialized accessibility/safety adaptations/additions
   1. Door-widening
   2. Electrical wiring
   3. Grab bars and handrails
   4. Automatic door openers/doorbells
   5. Voice activated, light activated, motion activated and electronic devices
   6. Fire safety adaptations
   7. Medically necessary air filtering devices
   8. Medically necessary heating/cooling adaptations

f. Trained and certified animal assistance
   1. Purchase of trained animal
   2. Training for recipient and animal
   3. Animal upkeep (food, license, tax, supplies)
   4. Emergency and preventative Veterinarian services

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.

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

Limitations: Each environmental adaptation must be: 1) documented as medically necessary by a physician; 2) prior approved by DSPD in accordance with written policy including defined qualifying criteria; and 3) documented as not otherwise available as a Medicaid State Plan service. Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual. General household repairs are not included but repairs to housing modifications will be allowed, as necessary, if identified in the individual's support plan. These repairs must be limited to the repair of previously approved modifications or adaptations that are directly and exclusively related to allowing the individual to remain in housing within their community and avoid placement in a Nursing Facility (NF). All services shall be provided in accordance with applicable State or local building codes.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Home 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	Current business license.		Under state contract with DSPD as an authorized provider of services and

Supplier	(and Contractor's license when applicable)		supports to people with disabilities in accordance with 62A-5-103, UCA.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Environmental Adaptations Supplier	Division of Services for People with Disabilities	Annually

Service Delivery Method

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

Service Specification

Service Title:	**Environmental Adaptations - Vehicle**

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.
X	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Environmental Adaptations for the vehicle involve equipment and/or physical adaptations to the individual's vehicle that are necessary to assure the health, welfare and safety of the individual or enhance the individual's level of independence. The equipment/adaptations are identified in the individual's support plan and a qualified professional specifies the model and type of equipment. The adaptations may include purchase, installation, and repairs. Such equipment/adaptations include:

a. Lifts
b. Door modifications
c. Steering/braking/accelerating/shifting modifications
d. Seating modifications
e. Safety/security modifications

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.

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

Limitations: Each environmental adaptation must be: 1) documented as medically necessary by a physician; 2) prior approved by DSPD in accordance with written policy including defined qualifying criteria; and 3) documented as not otherwise available as a Medicaid State Plan service. Excluded are

those adaptations or improvements to the vehicle, which are of general utility, and are not of direct medical or remedial benefit to the individual. General vehicle repairs are not included but repairs to vehicle modifications will be allowed, as necessary, if identified in the individual's support plan. These repairs must be limited to the repair of previously approved modifications or adaptations that are directly and exclusively related to allowing the individual to remain in housing within their community and avoid placement in a Nursing Facility (NF). All services shall be provided in accordance with applicable State or local vehicle codes.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Vehicle 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)		Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Environmental Adaptations Supplier	Division of Services for People with Disabilities	Annually

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

Service Specification	
Service Title:	**Transportation Services (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.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Transportation Services serves the purpose of allowing the individual access to other waiver supports necessary to live an inclusive community life. Individuals receiving services are trained, assisted, and provided opportunities to use regular transportation services available to the general public in their community. If regular transportation services are not available or do not meet the needs of the waiver enrollee, waiver non-medical transportation becomes an option.

Transportation Supports are only provided as independent waiver services when transportation is not otherwise available as an element of another waiver service. The need for transportation must be documented as necessary to fulfill other identified supports in the individual support plan and the associated outcomes.

Elements of Transportation Services:
The Transportation Services category consists of elements for enrollee/family arranged transportation, for transportation by an agency-based provider, and for a multi-pass for a public transit system.

Daily services/rates are rendered as a flat daily rate independent of the number of trips per day.

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

Limitations: Medicaid payment for transportation under the approved waiver plan is not available for medical transportation. Medical transportation is defined as transportation covered by the State Plan that transports individuals to medical services that are covered by the State Plan. In addition, Medicaid payment is not available for any other transportation available thru the State plan, transportation that is available at no charge, or as part of administrative expenditures. Additional transportation supports will not be available to community living, day habilitation, or supported employment providers contracted to provide transportation to and from the person's residence to the site(s) of a day program when payment for transportation is included in the established rate paid to the provider.

Additionally, this service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services for the purposes of visitation to a family home.

Provider Specifications

Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Self-directed service provider		Transportation provider	

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

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

State:	
Effective Date	

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Self-directed--Non-Medical Transportation	Individual with driver's license and registered vehicle, per 53-3-202, UCA and 41-12a-301 through 412, UCA	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	• Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA and R539-5. • Driver must possess a current Utah Driver License and proof of auto liability insurance in amounts required by state law.
Agency-based—Non-Medical Transportation	Licensed public transportation carrier OR Individual with driver's license and registered vehicle, per 53-3-202, UCA and 41-12a-301 through 412, UCA Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	• Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. • Driver must possess a current Utah Driver License and proof of auto liability insurance in amounts required by state law. • Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Non-Medical Transportation Providers	Division of Services for People with Disabilities	Annually

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

Service Specification

State:	
Effective Date	

Service Title:	**Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee**
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.
X	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Specialized Medical Equipment/Supplies/Assistive Technology—Monthly Fee is a periodic service (e.g., monthly) fees for ongoing support services and/or rental associated with devices, controls, or appliances, specified in the individual support plan, which enable individuals 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 also includes 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. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items that are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

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

Limitations: Expenditures for specialized medical equipment and supplies will be in accordance with Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and medical supplies must be prior approved based on a determination of medical necessity, a determination that the item is not available as a Medicaid State Plan service, and a determination that rental or payment of a monthly fee for equipment or supplies is a more cost effective than purchasing the equipment outright.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	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		Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

			Enrolled as a Medicaid provider

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Medical equipment and supply suppliers	Division of Services for People with Disabilities	Annually

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

Service Specification	
Service Title:	**Specialized Medical Equipment/Supplies/Assistive Technology - Purchase**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	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/Supplies/Assistive Technology – Purchase includes the purchase of devices, controls, or appliances, specified in the individual support plan, which enable individuals 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 also includes 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. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items that are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

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

Limitations: Expenditures for specialized medical equipment and supplies will be in accordance with Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and medical supplies must be prior approved based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	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		Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Medical equipment and supply suppliers	Division of Services for People with Disabilities	Annually

Service Delivery Method

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

Service Specification

Service Title:	Personal Emergency Response System

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

X	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)**:**

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

Personal Emergency Response System is an electronic device of a type that allows the individual requiring such

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

Elements of Personal Emergency Response System:
Installation and testing of the Personal Emergency Response System
Monthly Fee is the periodic service fees (e.g., monthly) for ongoing support services and or rental associated with the Personal Emergency Response System
Purchase of Personal Emergency Response System

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Personal Emergency Response System suppliers and 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 Response System Supplier	Current business license		FCC registration of equipment placed in individual's home. Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider
Emergency Response System Supplier **Personal Emergency Response System Installer** **Personal Emergency Response Center**	Current business 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 Services for People with Disabilities**	**Annually**

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

Service Specification	
Service Title:	Living Start-Up Costs
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.
X	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Living Start-Up Cost are for individuals transitioning from a more restrictive living arrangement to a less restrictive living arrangement, this service provides reimbursement for the purchase of essential household items needed to establish basic living arrangements that allow the individual to live safely in the community. Essential household items include a bed, a table, chairs, bathroom furnishings, pots, pans, storage containers, utensils, broom, vacuum, plates, dishes, bowls, cups, telephone, answering machine, alarm clocks, hangers, duplicate keys, locks, non-refundable set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating).

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

Limitations: 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 entertainment and diversional items such as televisions, stereos, DVD players, VCR's, CD players, or gaming systems, etc. is prohibited. Reimbursement for the cost of refundable fees or deposits is not a covered expense under this service.

This service requires prior authorization by a Division of Services for People with Disabilities designee and is only available to those transitioning from a more restrictive living arrangement to a less restrictive living arrangement. This service is available only after attempts to access start-up items from all alternative sources have been exhausted. Efforts to access alternative sources must be documented in the individual's case file. Copies of this documentation must be submitted to the Division of Services for People with Disabilities prior

authorization designee for review. This service is only available for assisting individuals in transitioning to a living arrangement in a private residence where the person is responsible for his or her living expenses.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				State of Utah Department of Human Services, Division of Services for People with Disabilities

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)*
Living Start-up Costs Provider			Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Living Start-up Costs Provider	**Division of Services for People with Disabilities**	**Annually**

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

Service Specification	
Service Title:	Chore Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	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)**:**

Chore Services serve the purpose of maintaining a clean, sanitary and safe living environment in the individual's residence.

Chore Services involve heavy household tasks such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress.

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

Limitations: These services will be provided only in cases where the individual lacks the ability to perform or financially provide for the services, and no other relative, caregiver, landlord, community/volunteer agency, third party payer, or other informal support system is capable of or responsible to perform or financially provide for the services. In the case of rental property, the responsibility of the landlord, pursuant to the lease arrangement, will be examined prior to any authorization of service.

Provider Specifications

Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Self-directed services provider		Chore service providers	

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

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Self-directed--Chore Services		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA and R539-5. Completed Provider Agreement
Agency-based—Chore Services	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Chore Services	**Division of Services for People with Disabilities**	**Annually**

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

Service Specification	
Service Title:	Companion 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.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Companion Services involve non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the Individual Support Plan, and is not purely diversional in nature. Daily services/rates are rendered for six hours or more per day.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Limitations: Companion Services are not available to individuals receiving other waiver services in which the services are essentially duplicative of the tasks defined in Companion Services. Individuals receiving services within the Day Supports or Supported Living may receive Companion Services only on an hourly and not a daily basis, when the need exists and approval has been granted in advance for the utilization of this service by the appropriate DSPD region. This service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Self directed service provider		Companion Services provider	

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

State:	
Effective Date	

applies):					

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Self-directed--Companion Services Provider		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA and R539-5. Completed Provider Agreement
Agency-based—Companion Services Provider	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Companion Services Provider	**Division of Services for People with Disabilities**	**Annually**

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

Service Specification	
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.
X	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Consumer Preparation Services ensure that waiver recipients are prepared to supervise and direct their self-administered services providers. Consumer Preparation Services includes: (a) instruction in methods of identifying need and effectively communicating those needs to service providers; (b) instruction in management of provider(s) including interviewing, selecting, scheduling, termination, time sheeting, evaluating performance, back up coverage; (c) instruction in addressing problems such as changing levels of personal needs, grievance procedures, emergency coverage, exploitation and abuse. Consumer Preparation Services do not include educational, vocational or prevocational components.

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

Limitations: Limits on the amount, frequency and/or duration are specified on the individual's plan of care and based on assessed need.

Provider Specifications				
Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				Consumer Preparation Services Provider

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—Consumer Preparation Services Provider	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Consumer Preparation Services Provider	**Division of Services for People with Disabilities**	**Annually**

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

Service Title:	Behavior Consultation I
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.
X	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Behavior Consultation I

Includes the provision of generally accepted educational procedures and techniques that are designed to decrease problem behavior and increase appropriate replacement behaviors. This service is intended to assist individuals in acquiring and maintaining the skills necessary for the capacity to live independently in their communities and avoid placement in a Nursing Facility (NF) and therefore, this service is intended to be *habilitative* in nature. Consultations are based upon the well-known and widely regarded principles of applied behavior coaching and focus on positive behavior supports. Behavioral consultants provide services to individuals whose behavior problems may be emerging, annoying, worrisome, objectionable, singular but not dangerous, and may interfere with learning or social relationships. The behaviors of the person shall not constitute an impending crisis, nor shall they be assessed as constituting a serious problem. The family and/or support staff with whom the consultant is working will have no special needs/issues beyond consultation and skill training and will be capable of coordinating with schools, agencies, and others as needed. Consultation may include the development of a behavior program which employs widely accepted principles of applied behavior analysis that are applicable to many and which focus on the provision of positive behavioral supports (and which does not included any intrusive interventions). Services are to be provided in the person's residence or other naturally occurring environment in the community.

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

Limitations: This service will not be available to individuals who might otherwise receive this service through the Medicaid State Plan or any other funding source.

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Behaviorist		Behavior Consultation I service provider	

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)*
Behaviorist	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA Training and experience in the field of acquired brain injuries of at least one year's length; completion of a training course in positive behavioral supports prescribed by DSPD and approved by the SMA and the successful completion of a learning assessment at the conclusion of the course. Enrolled as a Medicaid provider
Agency-based—Behavior Consultation Service I	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA Training and experience in the field of acquired brain injuries of at least one year's length; completion of a training course in positive behavioral supports prescribed by DSPD and approved by the SMA and the successful completion of a learning assessment at the conclusion of the course. Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Behavior Consultation Service I Provider	**Division of Services for People with Disabilities**	**Annually**

Service Delivery Method				
Service Delivery Method *(check each*		Participant-directed as specified in Appendix E	X	Provider managed

that applies):				

Service Specification	
Service Title:	Behavior Consultation II
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.
X	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Behavior Consultation II includes the provision of educational procedures and techniques that are designed to decrease problem behavior and increase appropriate replacement behaviors. This service is intended to assist individuals in acquiring and maintaining the skills necessary for the capacity to live independently in their communities and avoid placement in a Nursing Facility (NF) and therefore, this service is intended to be *habilitative* in nature. Interventions are based upon the principles of applied behavior analysis and focus on positive behavior supports. Behavior consultants provide individual behavior consultation to families and/or staff who support individuals with *serious* though not potentially life threatening behavioral problems that may be complicated by medical or other factors. Problems addressed by behavior consultants are identified as serious, but have not been judged to be treatment resistant or refractory. Consultation shall include designing the behavior support plan and training the family and/or support staff on a behavior support plan developed specifically for the person being served. Services are to be provided in the person's residence or other naturally occurring environment in the community. This service is consultative in nature and does not include the provision of any direct services to consumers.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Limitations: Contractors are not permitted to provide direct care to persons (i.e. bathing, feeding, dressing, or supervision) nor are they allowed to transport persons receiving services. This service is not available to individuals eligible to receive this service through the Medicaid State Plan or other funding source.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Behaviorist		Behavior Consultation II service provider	

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)*
Behaviorist	Current business license	Certified by DSPD as an authorized provider of services and supports to people with	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA Board Certified Associate Behavior Analysts

		disabilities in accordance with 62A-5-103, UCA.	(BCABA); or proof of achievement of a post-graduate degree of at least a Masters' in a behaviorally-related field as well as experience of at least one year working in the field of brain injury or other related conditions. Completion of a training course in positive behavioral supports prescribed by DSPD and approved by the SMA and the successful completion of a learning assessment at the conclusion of the course.
Agency-based—Behavior Consultation Service II	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA Board Certified Associate Behavior Analysts (BCABA); or proof of achievement of a post-graduate degree of at least a Masters' in a behaviorally-related field as well as experience of at least one year working in the field of brain injury or other related conditions. Completion of a training course in positive behavioral supports prescribed by DSPD and approved by the SMA and the successful completion of a learning assessment at the conclusion of the course. Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Behavior Consultation Service II Provider	**Division of Services for People with Disabilities**	**Annually**

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

Service Specification	
Service Title:	Behavior Consultation Service III
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.
X	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Behavior Consultation Service III includes the provision of educational procedures and techniques that are designed to decrease problem behavior and increase appropriate replacement behaviors. This service is intended to assist individuals in acquiring and maintaining the skills necessary for the capacity to live independently in their communities and avoid placement in a Nursing Facility (NF) and therefore, this service is intended to be *habilitative* in nature. Interventions are based upon the principles of applied behavior analysis and focus on positive behavior supports. Behavioral consultants provide individual behavioral consultation to families and/or staff who support individuals with the most *involved, complex, difficult, dangerous*, potentially *life threatening* and resistant to change behavioral problems. The serious behavioral problems may be complicated by medical or other factors. In addition, eligible persons must have failed alternative interventions and are severely limited in their activities and opportunities due to their behavioral problems. Consultation shall include designing and training the family and/or support staff on a behavior support plan developed specifically for the person being served. Services are to be provided in the person's residence or other naturally occurring environment in the community. This service is consultative in nature and does not include the provision of any direct services to consumers.

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

Limitations: Contractors are not permitted to provide direct care to persons (i.e. bathing, feeding, dressing, or supervision) nor are they allowed to transport persons receiving services. This service is not available to individuals eligible to receive this service through the Medicaid State Plan or other funding source.

Provider Specifications

Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Behaviorist		Behavior Consultation Service III Provider	

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)*
Behaviorist	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA Board Certified Behavior Analysts (BCBA); or proof of achievement of a post-graduate degree of a doctoral level in a behaviorally related field and a combination of training and experience equivalent to that required for certification as a Board Certified Behavior Analysts.
Agency-based--	Current business	Certified by DSPD	Under state contract with DSPD as an

Behavior Consultation Service III Provider	license	as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA Board Certified Behavior Analysts (BCBA); or proof of achievement of a post-graduate degree of a doctoral level in a behaviorally related field and a combination of training and experience equivalent to that required for certification as a Board Certified Behavior Analysts. Enrolled as Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Behavior Consultation Service III Provider	**Division of Services for People with Disabilities**	**Annually**

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

Service Specification	
Service Title:	Extended Living Supports
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.
X	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Extended Living Supports provides supervision, socialization, personal care and supports for persons who reside in a community living setting during the period of time they would normally be attending an employment, day or school program. Extended living supports are intended to be utilized for short periods of time, such as illness, recovery from surgery and/or transition between service providers and are not intended for long term use in lieu of supported employment, day supports or school programs.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Limitations: Individuals receiving Extended Living Supports may not receive Day Supports Services simultaneously.	

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Extended Living Supports Provider

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)*
Extended Living Supports Provider	R501-2 UAC, R539-6 UAC (4 or more individuals)	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Extended Living Supports Provider	**Division of Services for People with Disabilities**	**Annually**

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

Service Specification	
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.
X	Service is not included in the approved waiver.

Service Definition (Scope):
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. Daily services/rates are rendered for six hours or more per day.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Self-directed service provider		Personal Budget Assistance Provider	

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

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Self-directed—Personal Budget Assistance Provider		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA and R539-5. Completed Provider Agreement
Agency-based—Personal Budget Assistance Provider	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Budget Assistance Provider	**Division of Services for People with Disabilities**	**Annually**

Service Delivery Method				
Service Delivery Method	X	Participant-directed as specified in Appendix E	X	Provider managed

(check each that applies):				

Service Specification	
Service Title:	Professional Medication Monitoring
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.
X	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Professional Medication Monitoring provides testing and nursing services necessary to provide medication management to assure the health and welfare of the person. This service includes regularly scheduled, periodic visits by a nurse in order to conduct an assessment of the individual with regard to their health and safety particularly as it is affected by the maintenance medication regimen that has been prescribed by their physician, to review and monitor for the presence and timely completion of necessary laboratory testing related to the medication regimen, and to offer patient instruction and education regarding this medication regimen. Nurses will also provide assistance to the individual by ensuring that all pill-dispensing aids are suitably stocked and refilled.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Limitations: This service is not available to individuals eligible to receive this service through the Medicaid State Plan or other funding source.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	RN or LPN		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)*
Professional Medication Monitoring Provider	RN and LPN: Sec. 58-31b, UCA and R156-31b UAC		Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider
Home Health Agency	Licensed Home Health Agency	Certified Home Health Agency	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Professional Medication Monitoring Provider	**Division of Services for People with Disabilities**	**Annually**

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

Service Specification	
Service Title:	Supported Living
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.
X	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Supported Living constitutes individually tailored hourly support, supervision, training and assistance for people to live as independently as possible in their own homes, family homes and apartments. Supported living is available to those who live alone, with family or with roommates. For individuals residing with families, Supported Living is intended to provide support to the individual and the family to allow the family to continue providing naturals supports and to avoid unwanted out of home placement. Supported living activities are prioritized based upon the individual's assessed needs, but may include maintenance of individual health and safety, personal care services, homemaker, chore, attendant care, medication observation and recording, advocacy, communication, assistance with activities of daily living, instrumental activities of daily living, transportation to access community activities, shopping and attending doctor appointments, keeping track of money and bills and using the telephone; and indirect services such as socialization, self-help, and adaptive/compensatory skills development necessary to reside successfully in the community. This service may also include behavioral plan implementation by direct care staff.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Limitations: Individuals receiving Supported Living are not eligible to receive separate individual waiver services in addition to Supported Living if the separate services are essentially duplicative of the tasks defined in Supported Living. Individuals receiving Supported Living may not receive Residential Habilitation; however, they may receive Day Support Services as long as these services are not provided nor billed for times when the individual is receiving Supported Living services	

Provider Specifications				
Provider Category(s)	X	Individual. List types:	X	Agency. List the types of agencies:
	Self-directed services provider		Supported Living Provider	

(check one or both):		

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

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Self-directed—Supported Living		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA and R539-5.
Agency-based—Supported Living	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Supported Living Provider	**Division of Services for People with Disabilities**	**Annually**

Service Delivery Method

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

Service Specification

Service Title:	Cognitive Retraining 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.
X	Service is not included in the approved waiver.

Service Definition (Scope):
This service is provided to the individual and/or their family members to assist in the management, compensation, or restoring of cognitive function (e.g. ability/skills for learning, analysis, memory, attention, concentration, orientation, and information processing). Skills are practiced and strategies are taught to help improve function and/or compensate for remaining deficits through the use of compensatory strategies and cognitive tools. The interventions are based on an assessment and understanding of the person's brain-behavior deficits, and will be reflected in the Person Centered Support Plan. Prior authorization is required.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Treatment is not covered for: Clients for whom there is no documented potential for functional improvement; Clients who have reached maximum potential for functional improvement; Clients who have achieved stated goals; Non-diagnostic, non-therapeutic, routine, repetitive or reinforced procedures. The additional amount of services that may be provided through the waiver is limited to the duration or frequency determined necessary through the comprehensive needs assessment process and delineated in the individual's service plan, but is not otherwise limited by definition in terms of duration or frequency

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Occupational Therapist		Home Health Agency	
	Speech-Language Pathologist			
	Psychologist			

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)*
Occupational Therapist	Must hold a current professional license in the State of Utah as described in the State of Utah Occupational Licensing Act Title 58, Chapter 42a.		Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider BCI check Must carry Malpractice Insurance
Speech-Language Pathologist	Must hold a current professional license in the State of Utah		Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with

	as described in the State of Utah Speech Pathology and Audiology Licensing Act Title 58, Chapter 41 may provide services only in that licensed specialty, and may supervise according to State Licensing Law.		62A-5-103, UCA. Enrolled as a Medicaid provider BCI check Must carry Malpractice Insurance
Psychologist	Must hold a current professional license in the State of Utah as described in the State of Utah Psychologist Licensing Act Title 58, Chapter 60.		Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider BCI check Must carry Malpractice Insurance
Home Health Agency	Licensed Home Health Agency	Certified Home Health Agency	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Occupational Therapist	**DSPD**	**Annually**
Speech-Language Pathologist	**DSPD**	**Annually**
Psychologist	**DSPD**	**Annually**
Home Health Agency	**DSPD**	**Annually**

Service Delivery Method

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

Service Specification	
Service Title:	Speech-Language Services Extended State Plan
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.
X	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Speech-Language Extended State Plan services are provided in addition to speech-language services furnished under the approved State plan. These services are provided when speech-language services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from speech-language services furnished under the State plan and are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.

Speech-Language Services include examination, diagnosis, correction or amelioration of speech-language disorders, abnormalities, behavior, or their effects.

Prior authorization is required.

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

Limitations:
Speech-language extended State plan services will only be ordered after full utilization of available State Plan speech-language services by the individual.

Services for abnormal pitch, quality, tone, fluency or rhythm are not Medicaid benefits, except when due to accident or injury.

Treatment is not covered for:
Clients for whom there is no documented potential for functional improvement;
Clients who have reached maximum potential for functional improvement;
Clients who have achieved stated goals;
Non-diagnostic, non-therapeutic, routine, repetitive or reinforced procedures

The additional amount of services that may be provided through the waiver is limited to the duration or frequency determined necessary through the comprehensive needs assessment process and delineated in the individual's service plan, but is not otherwise limited by definition in terms of duration or frequency.

Provider Specifications

Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Speech-Language Pathologist		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)*
Speech-Language Pathologist	Must hold a current professional license in the State of Utah as described in the State	Certified by DSPD as an authorized provider of services and supports to people	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

	of Utah Speech Pathology and Audiology Licensing Act Title 58, Chapter 41 may provide services only in that licensed specialty, and may supervise according to State Licensing Law.	with disabilities in accordance with 62A-5-103, UCA.	Enrolled as a Medicaid provider Must have BCI Check Must carry malpractice insurance
Speech-Language Pathology Aide			Must meet the minimum qualifications established by the board for speech-language pathology aides, does not act independently, and works under the personal direction and direct supervision of a licensed speech-language pathologist.
Home Health Agency	Licensed Home Health Agency	Certified Home Health Agency	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Speech-Language Pathologist	**DSPD**	**Annually**
Home Health Agency	**DSPD**	**Annually**

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

Service Specification	
Service Title:	Physical Therapy Extended State Plan
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.
X	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Physical Therapy Extended State Plan services are provided in addition to physical therapy services furnished under the approved State plan. These services are provided when physical therapy services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from physical therapy services furnished under the State plan and are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.	

Physical Therapy means (1) treatment by the use of exercise, massage, heat or cold, air, light, water, electricity, or sound in order to correct or alleviate a physical or mental condition or prevent the development of a physical or mental disability, or (2) the performance of tests of neuromuscular function as an aid to diagnosis or treatment.

Prior authorization is required.

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

Limitations:
Physical therapy extended State plan services will only be ordered after full utilization of available State Plan physical therapy services by the individual.

Treatment is not covered for:
Clients for whom there is no documented potential for functional improvement;
Clients who have reached maximum potential for functional improvement;
Clients who have achieved stated goals;
Non-diagnostic, non-therapeutic, routine, repetitive or reinforced procedures.

The additional amount of services that may be provided through the waiver is limited to the duration or frequency determined necessary through the comprehensive needs assessment process and delineated in the individual's service plan, but is not otherwise limited by definition in terms of duration or frequency.

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Physical Therapist		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)*
Physical Therapist	Must hold a current professional license in the State of Utah as described in the State of Utah Physical Therapy Licensing Act Title 58, Chapter 24a.	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Be an enrolled provider for the Utah Medicaid Program BCI Check Must carry malpractice insurance
Home Health Agency	Licensed Home Health Agency	Certified Home Health Agency	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

			Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Physical Therapist	**DSPD**	**Annually**
Home Health Agency	**DSPD**	**Annually**

Service Delivery Method

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

Service Specification

Service Title:	Occupational Therapy Extended State Plan

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.
X	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Occupational Therapy Extended State Plan services are provided in addition to occupational therapy services furnished under the approved State plan. These services are provided when occupational therapy services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from occupational therapy services furnished under the State plan and are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.

Occupational therapy is therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and to those who have or are at risk of developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restrictions. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

Occupational therapy means the treatment of a human being by the use of therapeutic exercise ADL activities, patient education, family training, home environment evaluation, equipment measurement and fitting or other modalities approved by the American Occupational Therapy Association.

Prior authorization is required.

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

Limitations:
Occupational therapy extended State plan services will only be ordered after full utilization of available State Plan occupational therapy services by the individual.

Treatment is not covered for:
Clients for whom there is no documented potential for functional improvement;
Clients who have reached maximum potential for functional improvement;
Clients who have achieved stated goals;
Non-diagnostic, non-therapeutic, routine, repetitive or reinforced procedures

The additional amount of services that may be provided through the waiver is limited to the duration or frequency determined necessary through the comprehensive needs assessment process and delineated in the individual's service plan, but is not otherwise limited by definition in terms of duration or frequency

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Occupational Therapist		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)*
Occupational Therapist	Must hold a current professional license in the State of Utah as described in the State of Utah Occupational Licensing Act Title 58, Chapter 42a.		Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider BCI check Must carry Malpractice Insurance
Occupational Therapist Assistant	Must hold a current professional license in the State of Utah as described in the State of Utah Occupational Licensing Act Title 58, Chapter 42a.		Treatment provided by a COTA must be initiated and supervised by an OTR. The COTA can only follow a treatment plan developed by the OTR. COTA's need supervision every two weeks with an onsite visit from the OT once a month.
Home Health Agency	Licensed Home Health Agency	Certified Home Health Agency	Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Occupational Therapist	**DSPD**	**Annually**
Occupational Therapist Assistant	**DSPD**	**Annually**

Home Health Agency	DSPD	Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	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.
X	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 annual sampling 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.*
X	**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:	Person Centered Support Plan (PCSP)

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)
X	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:*

X	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*:

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 Support Coordinator ensures that the participant, legal representative, primary paid service providers, and any others at the invitation of the participant are involved throughout the assessment and planning process. The Support Coordinator completes the Supports Intensity Scale (SIS) with the participant, legal representative, and/or family as respondents, and the results of this are shared with all parties who have been included in this process. A planning meeting is held where the participants are involved in the

development of their Person-Centered Profile, which is an element of the Person Centered Support Plan. Participants are also involved in selecting personal goals and making decisions that are related to specific supports in their Action Plan.

The participant or legal representative is asked to invite anyone they wish to participate in the planning process. During the planning process, the participant is given the freedom to select their Support Coordinator and waiver services providers.

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 ABI Waiver support coordinator develops the Participant Centered Service Plan (PCSP) in consultation with the participant and/or the participant's representative and others as necessary and appropriate. The PCSP is reviewed as frequently as necessary, with a formal review at least annually, and is completed during the calendar month in which it is due. The State utilizes the PCSP as a means of identifying the array of services that will meet the participant's assessed needs. Annual individual budgets are developed with sufficient funds allocated to cover the array of services indicated on the PCSP. The PCSP and the budget are reviewed and agreed upon by the participant and the support coordinator. The PCSP and the budget are changed during the course of the year, as needed, to address participants' changing needs.

The primary assessment tool conducted to support service plan development is the American Association of Intellectual and Developmental Disabilities' (AAIDD) Supports Intensity Scale (SIS). Other assessments include: review of the previous year's assessment, the Person-Centered Profile, and educational, psychological, psychiatric, medical and other therapy evaluations as needed.

<u>a) who develops the plan, who participates in the process, and the timing of the plan;</u>
The Support Coordinator has ultimate responsibility to develop the PCSP; however, it is the entire team's responsibility to participate. The team must consist of at least the participant and legal representative, Support Coordinator, primary paid service providers and others as invited by the participant. The PCSP is reviewed and updated at least once a year with changes made throughout the year as needed based on the participant's needs. Anytime during the plan year the Support Coordinator can choose to complete a whole new plan or make modifications (addendums) to the existing plan.

<u>(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.</u>

The ABI Waiver utilizes a comprehensive approach to service plan development. The American Association of Intellectual and Developmental Disabilities' (AAIDD) Supports Intensity Scale (SIS) is the primary assessment tool for the development of the Person

Centered Support Plan (PCSP). Other important assessments include: the Comprehensive Brain Injury Assessment, the Person- Centered Profile, educational assessments, psychological assessments, psychiatric assessments, medical assessment, other therapy evaluations as needed and the review of the past year.

(c) how the participant is informed of the services that are available under the waiver.

Prior to the initial planning meeting the participant or the participant's representative is given a list of all the services provided on the ABI Waiver including the definition of each service. In addition, the list of ABI services is found on the DSPD web site.

(d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences.

The SIS is a structured method to document what has been learned about the person and directly bridges the gap between assessing and planning. The SIS is administered prior to the initial planning meeting and at least every five years, thereafter, or more often as determined by the Support Coordinator. USTEPS has an edit check to ensure the SIS will be completed at a minimum within the five year time frame. Activities that the person indicates verbally or by their behavior is very important to them are identified. These include the person's passions, values, interests, preferences, personal goals. Health and safety concerns, as well as habilitation and training needs are identified as important for the participant.

The SIS is also reviewed prior to the annual planning meeting (or whenever the Support Coordinator deems necessary) to determine if it continues to accurately reflect the needs of the participant. If additional needs are identified the Support Coordinator may add these to the SIS. At the annual planning meetings the team discusses any additional information and determines any changes that need to be made to the service plan.

(e) how waiver and other services are coordinated.

The Action Plan lists all the person's supports and services including: Formal/Written Support Strategies, Medicaid State Plan Services, Natural Supports, One-Time and On-Going, Behavior Supports and Psychotropic Med Plans, Specific Medical, Skill Training, Opportunities, Relationship development, etc.

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan.

The Action Plan contains information about specific ABI Waiver services, including details on amount, duration, and frequency. It also includes, supports and services, who is providing the support, date the support will begin and end, and details: including provider requirements, such as, objectives, methods, procedures, data reporting, etc. The Action

Plan also includes information related to communication and coordination of services or supports with others. The payment source is also identified. For supports funded by the ABI Waiver the name of the contracted provider, the service code, and the requirement for support strategies and provider monthly summaries are documented

(g) how and when the plan is updated, including when the participant's needs change.

The plan is reviewed and revised as frequently as necessary to address participants changing needs. A formal review occurs at least annually and is completed during the calendar month in which it is due.

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

The primary tool for assessing risk is the Supports Intensity Scale. Additional risk screening items have been added to the SIS which is used to identify additional health and safety issues. These items are reviewed by the team and addressed in the PCSP as needed in the Action Plan. Back up plans are developed and incorporated into support strategies. Services that address risk are identified and included in the PCSP.

Prior to the planning meeting, the Support Coordinator completes the SIS by interviewing the participant, family, and provider staff to identify items important "for" the participant. These include health and safety areas of need and risk. The Support Coordinator also reviews other assessments and the results of the past years supports. During the planning meeting the team reviews items identified as areas of concern. Decisions are made based on the participants identified needs and supports and services. Risks are described in support strategies and are tracked in Monthly Progress Notes from the service provider. Support strategies and services that address risk are followed up and addressed by support coordinators during visits with participants, families and providers. Issues are discussed with the Support Coordinator's supervisor and other pertinent individuals. DSPD supervisors, DSPD nurses, the DSPD behavior specialist and others are available to provide consultation to support coordinators for the mitigation of risks.

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.

The participant and/or representative are informed of all available qualified providers of waiver services during the PCSP planning meeting.

Each participant or legal representative is given a copy of the booklet, "An Introductory Guide—Division of Services for People with Disabilities that contains lists of contracted providers. The USTEPS case management system used to develop the PCSP includes pull down lists of all current providers for each specific waiver service. Support Coordinators will assist in arranging participants' visits with providers if needed to obtain more detailed

information. The participant's choice of providers of services is documented on the PCSP.

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

The SMA retains final authority for oversight and approval of the service planning process. The oversight function involves at a minimum an annual review of a sample of waiver enrollee's service plans that is representative of the caseload distribution across the program. The specific sample size of each review is selected based on the identified focus of the review and the number of reviews determined to be necessary to evaluate the waiver's performance. If the sample evaluation identifies system-wide service 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
X	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

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
X	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.

Support Coordinators are responsible to use a Person-Centered approach along with other formal and informal assessments to develop the Person Centered Support Plan (PCSP).

The Support Team will work with the participant to identify goals.

The Support Coordinator ensures that the PCSP is completed. If any interested party believes that PCSP is not being implemented as outlined, or receives a request from the participant/representative, they should immediately contact the Support Coordinator to resolve the issue by following the informal and, if necessary, the formal resolution process.

The Support Coordinator is responsible for ensuring that the PCSP is reviewed and updated as necessary to:

1. Record the participant's progress (or lack of progress)
2. Determine the continued appropriateness and adequacy of the participant's services; and
3. Ensure that the services identified in the PCSP are being delivered and are appropriate for the participant.

The PCSP is updated or revised as necessary by the Support Coordinator

The Support Coordinator monitors the implementation of the PCSP by doing the following:

1. Monthly face to face visits with the person (While monthly face to face visits is the standard, the Support Coordinator has the discretion to conduct face to faces visits with the client more frequently or less frequently than once a month. In all cases frequency will be dependent on the assessed needs of the client and will not exceed 90 days without a face to face visit).
2. Monthly review of progress reports
3. Working/ meeting with Providers and families of supports to ensure that participants are receiving quality supports in the environment of their choice.

PCSPs are reviewed at least every two years by DSPD and at least every five years by the SMA. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5. Records are reviewed for documentation that demonstrates participants have been made aware of all services available on the ABI waiver and have been offered choice among available providers. Records are also reviewed for compliance with health and welfare standards. This includes the documentation that prevention strategies are developed and implemented (when applicable) when abuse, neglect or exploitation is identified, verification (during face to face visits) that the safeguards and interventions are in place, notification of incidents to support coordinators has occurred , and documentation that participants have assistance, when needed, to take their medications and verification that back up plans are effective, Records are also reviewed to determine that the PCSP addresses all of the participant's assessed needs, including health needs, safety risks and personal goals either by the provision of waiver services or other funding sources (State Plan services, generic services and natural supports. Significant findings from these reviews

will be addressed with DSPD. A plan of correction with specific time frames for completion will be required. The SMA will conduct follow-up reviews as necessary to ensure the plan of correction is implemented and sustained.

b. Monitoring Safeguards. *Select one:*

X	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*:

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**	**PCSPs address all participants' assessed needs including health needs, safety risks and personal goals either by the provision of waiver services or other funding sources (State Plan, generic and natural supports.)**		
Data Source • **CBIA**	***Responsible Party for data collection/generation*** *(check each that*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

• **SIS** • **PCSP** • **Participant Records** • **Participant Interviews (PES)**	*applies)*		
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval* = 5
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* OA: At a minimum every two years. 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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. SMA: At a minimum every five years.	

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***Performance Measure:* #2**	**Documentation in the participant's record contains enough information to ascertain whether they have made progress on goals identified on the PCSP.**		
Data Source • **Participant Records** • **PCSP**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups* .
		X *Other: Specify:* OA: At a minimum every two years. 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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. SMA: At a minimum every five years.	

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Performance Measure: #3	**Services are not limited by funding. Once an individual is enrolled as a waiver participant, they are to receive the amount of covered services necessary to meet their health and welfare and to prevent unnecessary institutionalization.**		
Data Source • **Participant Records** • **PCSP** • **Participant Interviews (PES)**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* OA: At a minimum every two years. 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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:*	

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		OA: At a minimum every two years. SMA: At a minimum every five years.	

a.i.b Sub-assurance: The State monitors service 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**	**<u>Comprehensive Assessment</u>. The Supports Intensity Scale (SIS) is administered, at a minimum, every five years or more frequently as warranted.**		
Data Source • **SIS** • **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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* OA: At a minimum every two years. 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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. SMA: At a minimum every five years.	

Performance Measure: #2	**The SIS is reviewed at a minimum every 12 months.**		
Data Source • **SIS** • **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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* OA: At a minimum every two years. SMA: At a minimum every five years.	

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			Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. SMA: At the minimum every five years.	

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

For each performance measure/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**	**PCSPs are reviewed and updated at least annually.**		
Data Source • **PCSP** • **Participant Records** • **Participant Interviews (PES)**	***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)*
	X *State Medicaid*	☐ *Weekly*	☐ *100% Review*

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

Performance Measure: #2	**A comprehensive assessment is conducted when a significant change in the waiver participant's health status occurs.**		
Data Source • **CBIA** • **SIS**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

***Performance Measure:* #3**	**Service Plans are updated/revised when warranted by changes in the participant's needs.**		
Data Source • **CBIA** • **SIS** • **Participant Records** • **PCSP** • **Claims Data** • **Participant Interviews (PES)**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* OA: At a minimum every two years. 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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	

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	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. SMA: At a minimum every five years.	

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

For each performance measure/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 amount, frequency and duration for each service ordered authorized is clearly identified on the PCSP.**		
Data Source • **PCSP** • **Claims Data** • **Participant Interviews (PES)**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*

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

***Performance Measure:* #2**	**There is written verification that all services identified on the individual service plan are provided.**		
Data Source • **Participant Records** • **PCSP** • **Claims Data** • **Provider Monthly**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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Reports • **Participant Interviews (PES)**			
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* OA: At a minimum every two years. 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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. 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**	**Participants are offered the choice of either nursing facility care or ABI Waiver services.**		
Data Source • **Form 818b** • **Participant Interviews (PES)**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* OA: At a minimum every two years. 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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	

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Effective Date	

	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. SMA: At a minimum every five years.	

***Performance Measure:* #2**	**Participants are made aware of all services available on the ABI Waiver.**		
Data Source • **PCSP** • **Participant Records** • **Participant Interviews (PES)**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* OA: At a minimum every two years. 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*	

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

***Performance Measure:* #3**	**Participants are offered choice among providers.**		
Data Source • **PCSP** • **Participant Records** • **Participant Interviews (PES)**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* OA: At a minimum every two years. 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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. 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.

PCSPs are developed based on the *Supports Intensity Scale (SIS)* and in consultation with the participant and/or the participant's representative and address health needs, safety risks and personal goals. Documentation in the participant's record contains adequate information to ascertain the progress that a participant has made on goals identified on the service plan. Once an individual is enrolled in the waiver they are to receive the amount of covered services necessary to meet their health and welfare needs and to prevent unnecessary institutionalization. The comprehensive assessment is conducted when a participant enters the waiver and a screening is conducted at a minimum every twelve months. If there have been significant changes, the assessment is re-administered. All services are identified on the service plan regardless of funding source. Participants are offered choice of either nursing facility care or ABI Waiver services and choice is documented on the 818b form. Participants are made aware of all services available on the ABI Waiver and are offered choice among providers whenever choice exists. Choice of providers is documented in the participant's record. The SMA conducts an annual review of the ABI 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 both DSPD and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

The SMA may include as part of the sample, participants from prior reviews or participants

that were involved in complaints or critical incident investigations. At the conclusion of the review the SMA issues an initial report to DSPD (the operating agency). DSPD has three weeks to respond to or refute the findings. The SMA considers DSPD's response and the final report is issued. When warranted, the SMA will conduct follow up activities of findings from the DSPD report as part of the SMA review.

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 DSPD and the SMA 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)*
	X *State Medicaid Agency*	☐ *Weekly*
	X *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		X *Other: Specify:* OA: At a minimum every two years. 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 Service Plans that are currently non-operational.

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

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

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Effective Date	

State:	
Effective Date	

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)*:

X	**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.
X	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

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

Self-Administered Services are made available to all waiver enrollees who elect to participate in this method. Support Coordinators provide ongoing oversight of the enrollees' ability to successfully utilize self-administered services. Consumer Preparation services are available to recipients needing additional assistance and training in aspects of self-administration. Enrollees who subsequently demonstrate to their support coordinator their incapacity to successfully self-administer their services are transferred to Agency Based Provider Services.

Under Self-Administered Services, 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 sheets, etc. of the individual's employee/s. Individuals and/or their chosen representatives may avail themselves of the assistance offered them within the Consumer Preparation Service should they request and/or be assessed as requiring additional support and assistance in carrying out these responsibilities.

In the case of an individual who cannot direct his or her own services, including those who require a guardian, 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 service plan. The individual or appointed person may also train the employee to perform assigned activities. Appointed decision-makers cannot also be providers of self-administered services.

Waiver participants and/or their representatives hire employees in accordance with Federal Internal Revenue Service ("IRS") and Federal and State Department of Labor ("DOL") rules and regulations (IRS Revenue Ruling 87-41; IRS Publication 15-A: *Employer's Supplemental Tax Guide;* Federal DoL Publication WH 1409, Title 29 CFR Part 552, Subpart A, Section 3: *Application of the Fair Labor Standards Act to Domestic Service;* and States= *ABC Test*).

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

For persons utilizing the Self-Administered Services method, Financial Management Services are offered in support of the self-administered option. Financial Management Services, (commonly known as a "Fiscal Agent") facilitate the employment of individuals by the waiver recipient or designated representative including: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, fiscal accounting and expenditure reports, and (c) Medicaid claims processing and reimbursement distribution.

The individual receiving waiver services remains the employer of record, retaining control over the hiring, training, management, and supervision of employees who provide direct care services.

Once a person's needs have been assessed, the Person Centered Support Plan and budget have been developed and the individual chooses to participate in Self-Administered Services, the individual will be provided with a listing of the available Financial Management Services providers from which to choose. The individual will be referred to the Financial Management Services provider once a selection is made.

A copy of the individual's support plan/approved budget worksheet will be given to the chosen provider of Financial Management Services. The worksheet will indicate the person's total number of authorized funds. Allocated funds are only disbursed to pay for actual services rendered. All payments are made through Financial Management Services providers under contract with the Division of Services for People with Disabilities. Payments are not issued to the waiver recipient, but to and in the name of the employee hired by the person or their representative. The person will be authorized for a rate to cover the costs of the employee wages and benefits reimbursement.

The Support Coordinator monitors payments, reviews actual expenditure in comparison with the individual support plan and budget, contacts the waiver participant or their representative if any concerns arise, and assists in resolution of billing problems.

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

X	**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:*

X	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.
X	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*:
	Participant direction is offered to participants. 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/service 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. 4. Alternate service delivery methods are available to participants who have are not able to successfully direct their services.

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.

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

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.
X	The State provides for the direction of waiver services by a representative. Specify the

		representatives who may direct waiver services: *(check each that applies)*:
	X	Waiver services may be directed by a legal representative of the participant.
	X	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:
		Participants with adequate and appropriate information and with the assistance of legal representatives (if necessary), family members, and others in their chosen circle of support, can define, decide, and direct the set of waiver services authorized to be provided under the self-administered services model, that they receive. The informed preferences of the individual waiver recipient will be of primary importance in the decisions relevant to the selection and delivery of supports. As participants exercise greater choice and control over the supports they receive, they also assume relevant responsibility and accept reasonable risk associated with the decision they make. The manner in which the waiver recipient, state agencies and the providers of purchased supports share the responsibilities and risks related to services and supports will be defined in support plans, contracts, and other written agreements. In the case of an individual who cannot direct his or her own services, including those who require a guardian, 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 service plan. The individual or appointed person may also train the employee to perform assigned activities. Appointed decision-makers cannot also be providers of self-administered services. Necessary safeguards that are in place include the requirement that once chosen, the non-legal representative becomes a member of the person's individual support team. In addition to the non-legal representative, the individual support team consists of the participant's support coordinator, provider representatives and any other friends or family members of the participant's choosing. The Operating Agency relies on the decisions made by the individual's support team. If a non-legal representative and the team disagree with a decision made and or a non-legal representative appears to jeopardize a consumer's health and welfare, than the Operating Agency will take steps to resolve the disagreement and will assure the best interests of the participant are maintained. The health and safety of clients are ensured by routinely scheduled face-to-face visits by support coordinators, and by quality monitoring reviews by both the operating agency and the SMA.

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
Chore Services	X	☐
Companion Services	X	☐
Homemaker	X	☐
Personal Budget Assistance	X	☐
Respite	X	☐
Supported Living	X	☐

Transportation	X	☐

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

X	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	☐	Governmental entities
	X	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*:

X	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:	

Not applicable. FMS is not an administrative function.

The FMS uses a high and a low tier system. The tiers are determined by running a cluster analysis with a statistical software package. In order to be included in the analysis, the consumer must have been using the Self Administered System (SAS) model for the entire previous fiscal year. The parameters for inclusion in the analysis rely on data contained in the authorization file. In other words, when DSPD runs this year's analysis (to determine FY09 tiers), DSPD started with a list of everyone who was authorized to receive FMS on 7/1/2007 and was still authorized to receive it on the day DSPD ran it. Anyone without a full year of SAS services is left out of the analysis and they should remain in the low tier until they have a full fiscal year's worth of data.

Once DSPD has that list, we bring in two variables for the analysis. 1. The number of employees during the fiscal year and 2. The number of checks cut by the fiscal agent during the fiscal agent. DSPD relies on data from the fiscal agents for both of these variables. DSPD merges the lists together because some consumers switch fiscal agents mid-year. If they do change fiscal agents, DSPD counts each employee only once and we sum the number of checks cut. The data we use from the fiscal agents looks something like this for each consumer.

consumer_id count(distinct employee_SSN) sum(Checks_cut)

DSPD feeds this data set into the statistical software for the cluster analysis. A cluster analysis forces each consumer into one of two groups based on the number of employees and the number of checks. Obviously, consumers with a high number of checks and a high number of employees are forced into the high tier with the cluster analysis.

If a consumer is flagged by the cluster analysis as "high tier" then they need their budget increased. In other words, the additional funds to pay the difference between low and high tier is added to their budget (it should have no effect on their other services...they should still be allowed to receive the same amount of respite, PA, or whatever the service is the consumer receives).

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:	
	X	Assist participant in verifying support worker citizenship status
	X	Collect and process timesheets of support workers
	X	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
	X	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 DHS/DSPD 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:	
	X	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	X	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	X	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.	
	Service providers, support coordinators, and others who assist in the development and delivery of supports for people served through the Division of Services for People with Disabilities will be expected to maintain established standards of quality. The State Medicaid Agency and DSPD will assure that high standards are maintained by way of a comprehensive system of quality assurance including: (a) formal surveys of providers for measurement of individual and organizational outcomes, (b) contract compliance reviews, (c) regular observation and evaluation by support coordinators, (d) provider quality assurance systems, (e) consumer/family/legal representative satisfaction measures, (f) performance contracts with and reviews of State agency staff, (g) audits completed by entities external to the agency, and (h) other oversight activities as appropriate. The division improved the accountability of SAS service delivery through standardized mandatory training & manuals for SAS families and support coordinators, development of the Family to Family Network & Peer Mentors, and a formal documentation monitoring tool used by support coordinators to audit SAS employers.	

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)*:

X	**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:*
	In order to provide information and assistance to participants about self-directing their services, the Support Coordinator is responsible to provide the participant/representative with a Self-Administered Services Support Book. The support coordinator reviews the information in the Support Book with the participant/participant family and is available to answer any questions and provide assistance as needed. The support coordinator is responsible to assess whether the information provided is sufficient to meet the needs of the individual. If the assessment of the situation shows that the participant/representative requires additional training – such as hiring, scheduling, or training of employees, the support coordinator will order Consumer Preparation Services which is geared toward providing more detailed training on how to self-direct services. The support coordinator monitors payments, reviews actual expenditure in comparison with the PCSP and budget, contacts the waiver participant or their representative if any concerns arise, and assists in resolution of billing problems.
X	**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*:
X	**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:

DSPD will issue an Invitation for Service Offering (ISO) to all providers found qualified and available to render the services which the individual has elected to receive from an agency-based provider and will then enter into a contract for the provision of those services from the provider selected by the individual and their person-centered planning team. 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.

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.

All participants in the Waiver program are considered, de facto, to be eligible for self-administration. Only after a participant has repeatedly demonstrated an incapacity for self-administration or problems with fraud or malfeasance have been identified 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 repeated assistance rendered by case managers and/or through Consumer Preparation Services to assist the participant to acquire the skills necessary for self-administration. Only after the failure of all these efforts will the State involuntarily terminate self-administered services for a participant.

DSPD will terminate self-directed services involuntarily only upon the discovery of the individual's incapacity to self-administer as determined by the individual's person centered planning team. The Division will then issue an Invitation for Service Offering (ISO) to all providers found qualified and available to render the services which the individual has been assessed as requiring in order to have them receive these services from an agency-based provider and will then enter into a contract for the provision of those services from the provider selected by the individual and their person-centered planning team.

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.

In cases of fraud or misuse of funds, immediate termination of self-directed services is allowed. In these cases, DSPD would be responsible for obtaining an emergency provider of Waiver services until the ISO process is completed and the individual has the opportunity to choose their providers.

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 a Self-Administered Services Support Book 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.

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	16	N/A
Year 2	17	N/A
Year 3	18	N/A
Year 4 (renewal only)	19	N/A
Year 5 (renewal only)	20	N/A

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:*
X	**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*:

X	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
X	Hire staff (common law employer)
X	Verify staff qualifications
X	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	The operating agency (DSPD) is responsible to pay any fees associated with background investigations.
X	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.
X	Determine staff duties consistent with the service specifications in Appendix C-3.
X	Determine staff wages and benefits subject to applicable State limits
X	Schedule staff
X	Orient and instruct-staff in duties
X	Supervise staff
X	Evaluate staff performance
X	Verify time worked by staff and approve time sheets
X	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 service 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.

RIGHTS TO A FAIR HEARING DOCUMENTATION

1. DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

An individual and the individual's legal representative will receive a written Notice of Agency Action from the waiver support coordinator if the individual is denied a choice of institutional or waiver program, found ineligible for the waiver program, or denied access to the provider of choice for a covered waiver service in accordance with R539-2-5.

The Notice of Agency Action delineates the individual's right to appeal the decision. 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 (Form 490S) and directing the request be sent to the Department of Health, Division of Medicaid and Health Financing for a formal hearing and determination.

The person is informed through Form 522 (Appeals form), which states that a person's services will continue during the resolution/hearing process, when the person files the hearing request within 10 days of the postmark of the notice. The person's support coordinator will further inform the person of the right to receive services though the hearing process.

Notices and the opportunity to request a fair hearing documentation are kept in the individual's case record/file and at the Operating Agency - State Office.

The waiver individual support plan serves as the formal document identifying services that the waiver enrollee receives based on the comprehensive needs assessment. At the time a substantial change in a waiver enrollee's condition results in a change in the person's assessed needs, the individual support plan is revised to reflect the types and levels of service necessary to address the current needs. If the revisions to the individual support plan result in termination of a covered waiver service, reduction in the waiver services being received, or denial of services felt to be necessary to prevent institutionalization, the individual or legal representative has the right to appeal the decision to revise the individual support plan. 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 (Form 490S) and directing the request be sent to the Department of Health, Division of

Medicaid and Health Financing for a formal hearing and determination.

2. SINGLE STATE AGENCY

The State Medicaid Agency provides individuals applying for or receiving waiver services an opportunity for a hearing upon written request (see 1. above), if they are:

a. Not given the choice of institutional (NF) care or community-based (waiver) services;

b. Denied the waiver provider(s) of their 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; or

d. Experience a reduction, suspension, or termination in waiver services identified as necessary to prevent institutionalization.

It is the policy and preference of the single State agency to resolve disputes at the lowest level through open discussion and negotiation between the involved parties.

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*:

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

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

1. The Division staff explaining the regulations on which the action is based and attempt to resolve the disagreement.
2. If resolution is not yet reached, Division staff arranges a Region Review meeting between the individual and/or their legal representative and the Region Supervisor and/or the Region Director.
3. If the Region Review process is unsuccessful, Division staff arrange a Division Review meeting between the individual and/or their legal guardian and the Division Director and Region Director.

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

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

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

DSPD Policy 1.11 Conflict Resolution requires the case manager to provide information to recipients on the conflict resolution process and on how to contact the case manager's supervisor. The supervisor reviews all complaints submitted either orally or written and any relevant information submitted with the complaint. The supervisor will take appropriate action to resolve the dispute and

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

Appendix F-3: State Grievance/Complaint System

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

X	**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:

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

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

Waiver recipients may file a written or verbal complaint/grievance with the DHS/DSPD Constituent Service Representative. This Representative is specifically assigned to the Operating Agency, although operates independent of them. When the Representative receives a complaint there is an investigation involving all pertinent parties. The Representative then works with the parties to come to a resolution.

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

The types of complaints that can be addressed through the grievance/complaint system include but are not limited to: Complaints about a provider of waiver services, complaints about the way in which providers deliver services, complaints about individual personnel within a provider agency, etc.

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

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

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*:

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

The SMA requires that the DSPD administration report critical events/incidents within 24 hours of the event that occurs either to or by a participant. Reportable incidents or events include: unexpected or accidental deaths, suicide attempts, medication errors that lead to death or other serious outcomes, provider or caregiver neglect that results in death, hospitalization, or other serious outcomes, accidents that result in hospitalization, missing persons, human rights violations such as unauthorized use of restraints, criminal activities 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, and APS investigations that are in process and have a high probability of being supported. 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 (DSPD) Critical Event or Incident Reporting Requirements:

R539-5-6 requires the individual/ their representative or a provider agency to report to the case manager if at any time the participant's health and/or safety is jeopardized. Such instances may include, but are not limited to:

1. Actual or suspected incidents of abuse, neglect, exploitation or maltreatment per the DHS/DSPD Code of Conduct and Utah Code Annotated Sections 62-A-3-301 through 321 (mandatory reporting to Adult Protective Services)

2. Drug or alcohol misuse
3. Medication overdose or error requiring medical intervention
4. Missing person
5. Evidence of a seizure in person with no seizure diagnosis
6. Significant property destruction ($500.00 or more)
7. Physical injury requiring medical intervention
8. Law enforcement involvement
9. Emergency hospitalizations

The death of a waiver recipient is subject to a full review of the circumstances surrounding the death and includes a review of documentation by the DSPD Fatality review Coordinator for the most recent year of services.

Incidents that require reporting may be done verbally and must be made within 24 hours. Within 5 days the person reporting the incident completes the DSPD Form 1-8. If the person reporting is unable to complete the DSPD Form 1-8, accommodations are made and the administrative case manager writes the report.

The administrative case manager reviews the information, develops and implements a follow-up plan, as appropriate. The form and any follow-up conducted are filed in the individual's case record.

Incident reports are compiled, logged into the DSPD electronic database, analyzed and trends are identified. The information is utilized by the DSPD to identify potential areas for quality improvement. The DSPD generates a summary report of the incident reports annually (at minimum) and submits to the SMA.

If the SMA detects systemic problems DSPD must address DSPD will submit a plan of correction to the SMA. All plans of correction are subject to acceptance by the SMA. The SMA will conduct follow-up activities to determine that systems corrections have been achieved and are sustaining.

DSPD Provider Contract - Supervisory Requirements:
A. Incident Reports:
Within 24 hours of any incident requiring a report, the Contractor shall notify both the DHS/DSPD Support Coordinator and the person's Guardian by phone, email, or fax.

Within five (5) business days of the occurrence of an incident, the Contractor shall complete a DHS/DSPD Form 1-8 Incident Report and file it with the DHS/DSPD Support Coordinator at the DHS/DSPD Region Office. However, the mandatory reporting requirements of Utah Code § 62-A-3-301 through 321 for adults and, Utah Code §§ 62-4a-401 through 412 for children always take precedence. Therefore, in the case of actual or suspected incidents of abuse, neglect, exploitation, or maltreatment of an adult, the Contractor shall immediately notify Adult Protective Services intake or the nearest law enforcement agency, and shall immediately notify the Division of Children and Family Services Child Protective Services intake or the nearest peace officer, law enforcement

agency in a case involving a child.

The following situations are incidents that require the filing of a report:

1. Actual or suspected incidents of abuse, neglect, exploitation, or maltreatment per the DHS/DSPD Code of Conduct and Utah Code §§ 62-A-3-301 through 321, which can be found at http://www.le.state.ut.us/~code/TITLE62A/62A03.htm for adults; and, Utah Code §§ 62-4a-401 through 412 for children, which can be found at http://www.le.state.ut.us/~code/TITLE62A/62A04.htm.
2. Drug or alcohol abuse, medication overdoses or errors reasonably requiring medical intervention,
3. Missing person,
4. Evidence of seizure in a person with no existing seizure diagnosis,
5. Significant property destruction (damage totaling $500.00 or more). Property damage shall be covered by the Contractor's insurance unless it is agreed upon by the person's team that the person shall pay for damages,
6. Physical injury reasonably requiring a medical intervention,
7. Law enforcement involvement,
8. Any use of manual restraint, mechanical restraints, exclusionary time-out or time-out rooms as defined in Utah Administrative Code, Rule R539-4, and level II emergency interventions not outlined in the person's behavioral plan (e.g., response cost, overcorrection). http://rules.utah.gov/publicat/code/r539/r539.htm
9. Any other instances the Contractor determines should be reported.

After receiving an incident report, the DHS/DSPD Support Coordinator shall review the report and decide if further review is warranted.

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.

All providers, contracted with the operating agency, delivering direct services or supports to persons are responsible to ensure that a Provider Human Rights Plan is developed and a Human Rights Committee is established.

Each provider's Agency Human Rights Plan shall Identify the following:

1. Procedures for training persons/ consumers and staff on person's rights;
2. Procedures for prevention of abuse and rights violations;
3. Process for restricting rights when necessary;
4. Review of supports that have high risk for rights violations;
5. Responsibilities of the Contractor's Agency Human Rights Committee including the review of rights issues related to the supports a Contractor provides and give recommendations to the person/ consumer and their Support Team.

All persons/ consumers and staff shall have access to the Contractor's Human Rights Committee.

According to Utah Code 76-5-111.1. Reporting requirements -- Investigation -- Immunity -- Violation -- Penalty -- Physician-patient privilege -- Nonmedical healing.

(1) As provided in Section 62A-3-305, any person who has reason to believe that any vulnerable adult has been the subject of abuse, neglect, or exploitation shall immediately notify the nearest peace officer, law enforcement agency, or Adult Protective Services intake within the Department

Human Services, Division of Aging and Adult Services.

Training for Support Coordinators:

Within the first week of employment a Support Coordinator receives the "Support Coordinator Manual. This manual educates and trains a Support Coordinator of Legal Advocacy Programs and Policies, Child Protective Services, Adult Protective Services, as well as Abuse and Neglect reporting.

"According to Division's Staff Directive 1.18 "Division Support Coordination Training Requirements" states that by the end of the first year of employment, the Support Coordinator will complete more intensive training in the following areas:…one of them being Abuse, Neglect, and Exploitation."

Training for Employees working under the Self-Administered Method:
For employees working under the Self- Administered Method, employees are instructed and agree in their "Application for Certification to Provide Limited Services to an Individual under the Self-Administered Services" to review the Department of Human Services Provider Code of Conduct. The Code of Provider Conduct includes the areas of Abuse, Neglect, Maltreatment and Exploitation.

Training for Contracted Providers:
Department of Human Services (DHS)/DSPD service contracts contain a section that defines the frequency of training and education regarding protections from abuse, neglect, and exploitation. This is located in the ID.RC and ABI General Requirements, General Staff Training Requirements, paragraph B., and sub-paragraph 5, and paragraph C. Paragraph B., reads as follows:

> The Contractor's staff shall complete and achieve competency in general training areas 1 through 12 within 30 days of employment or before working alone with a person. Staff shall complete and achieve competency in general training areas 13 through 19 within six (6) months of employment. Staff competency in general training areas may be validated through reviews conducted by Center for Medicaid Services, Utah Department of Health and DHS/DSPD. The Contractor shall maintain a tracking system that ensures the following 19 general training area

requirements and timeframes are met:
Paragraph C., reads as follows:
In the second and subsequent years of employment, the Contractor's staff shall comp
minimum of 12 hours of training each year. The Contractor operating licensed facilit
shall train staff in behavior management each year per Utah Administrative Code, Ru
DHS, Office of Licensing (OL) (which may be referred to as DHS/OL) Rule R501-2-
http://rules.utah.gov/publicat/code/r501/r501-02.htm#T7

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

Responsibility of the State Medicaid Agency
After a critical incident/event is reported to the SMA by the Operating Agency, the Operating Agency investigates the incident/event and submits the *Critical Incident Findings, Operating Agency Report to SMA* to the SMA within two weeks of reporting the incident/event. Cases that are complicated and involve considerable investigation may require additional time to complete the findings document. The SMA reviews the report to determine if the incident could have been avoided, if additional supports or interventions have been implemented to prevent the incident from recurring, if changes to the care plan and/or budget have been made, if any systemic issues were identified and a plan to address systemic issues developed. Participants and/or legal representatives are informed in writing of the investigation results within two weeks of the closure of the case by the SMA.

Responsibility of the Operating Agency

The operating agency has responsibility for receiving, reviewing and responding to critical incidents.

Incidents involving suspected or actual abuse, neglect or exploitation will be reported to APS in accordance with Utah State Law 76-5-111 and State Rule R510-302. The operating agency will also report these instances to the SMA within 48 hours.

The operating agency will assure immediate interventions are taken to protect the health and welfare of the recipient (as circumstances warrant). An investigation is conducted to determine the facts, if the needs of the recipient have changed and warrant an updated needs assessment and identify preventive strategies for the future. The service plan is amended as dictated by the circumstances. The timeframe for completion of the investigation is 5 days from the date of notification.

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

Oversight Responsibility of Critical Incidents/Events of the State Medicaid Agency:
The SMA reviews 100% of critical incident reports, annually. The SMA also reviews the DSPD annual Incident Report. If the SMA detects systemic problems either through this reporting mechanism or during the SMA's program review process, DSPD will be requested to submit a plan of correction to the SMA. The plan of correction will include the interventions to be taken and the time frame for completion. All plans of correction are subject to acceptance by the SMA. The SMA will conduct follow-up activities to determine that systems corrections have been achieved and are sustaining.

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

The operating agency has responsibility for oversight of critical incidents and events. Incident reports are compiled, logged into the DSPD electronic database, analyzed and trends are identified. The information is utilized to identify prevention strategies on a system wide basis and identify potential areas for quality improvement.

The DSPD generates a summary report of the incident reports annually (at minimum) and submits it to the SMA.

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:
X	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).

R539-3-10. Prohibited Procedures.

(1) The following procedures are prohibited for Division staff and Providers, including staff hired for Self-Administered Services, in all circumstances in supporting Persons receiving Division funding:

(a) Physical punishment, such as slapping, hitting, and pinching.

(b) Demeaning speech to a Person that ridicules or is abusive.

(c) Locked confinement in a room. [definition of seclusion]

(d) Denial or restriction of access to assistive technology devices, except where removal prevents injury to self, others, or property as outlined in Sections R539-3-6 and R539-4-7.

(e) Withholding or denial of meals, or other supports for biological needs, as a consequence or punishment for problems.

(f) Any Level II or Level III Intervention, as defined in R539-4-3(n) and R539-4-3(o), used as coercion, as convenience to staff, or in retaliation.

(g) Any procedure in violation of R495-876, R512-202, R510-302, 62A-3-301 thru 62A-3-321, and 62A-4a- 402 thru 62A-4a-412 prohibiting abuse.

R539-4-4. Levels of Behavior Interventions.

(2) All Behavior Support Plans shall be implemented only after the Person or Guardian gives consent and the Behavior Support Plan is approved by the Team.

(3) All Behavior Support Plans shall incorporate Positive Behavior Supports with the least intrusive, effective treatment designed to assist the Person in acquiring and maintaining skills, and preventing problems.

(4) Behavior Support Plans must:

(a) Be based on a Functional Behavior Assessment.

(b) Focus on prevention and teach replacement behaviors.

(c) Include planned responses to problems.

(d) Outline a data collection system for evaluating the effectiveness of the plan.

(5) All Provider staff involved in implementing procedures outlined in the Behavior Support Plan shall be trained and demonstrate competency prior to

implementing the plan.

(a) Completion of training shall be documented by the Provider.

(b) The Behavior Support Plan shall be available to all staff involved in implementing or supervising the plan.

(8) Level II Interventions may be used in pre-approved Behavior Support Plans or emergency situations. [Includes manual restraint].

(9) Level III Interventions may only be used in pre-approved Behavior Support Plans. [Includes mechanical restraint and seclusion (time-out room)].

(10) Behavior Support Plans that utilize Level II or Level III Interventions shall be implemented only after Positive Behavior Supports, including Level I Interventions, are fully implemented and shown to be ineffective. A rationale on the necessity for the use of intrusive procedures shall be included in the Behavior Support Plan.

(11) Time-out Rooms shall be designed to protect Persons from hazardous conditions, including sharp corners and objects, uncovered light fixtures, and unprotected electrical outlets. The rooms shall have adequate lighting and ventilation.

(a) Doors to the Time-out Room may be held shut by Provider staff, but not locked at any time.

(b) Persons shall remain in Time-out Rooms no more than 2 hours per occurrence.

(c) Provider staff shall monitor Persons in a Time-out Room visually and auditorially on a continual basis. Staff shall document ongoing observation of the Person while in the Time-out Room at least every fifteen minutes.

(12) Time-out Rooms shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.

(a) Persons shall be placed in the Time-out Room immediately following a previously identified problem. Time delays are not allowed.

(b) Persons shall not be transported to another location for placement in a Time-out Room.

(c) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria.

(13) Mechanical restraints shall ensure the Person's safety in breathing, circulation, and prevent skin irritation.

(a) Persons shall be placed in Mechanical Restraints immediately following the identified problem. Time delays are not allowed.

(b) Persons shall not be transported to another location for Mechanical Restraints.

(14) Mechanical Restraints shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.

(a) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria. The plan shall also specify maximum time limits for single application and multiple use.

(b) Behavior Support Plans shall include specific requirements for monitoring the Person, before, during, and after application of the restraint to ensure health and safety.

(c) Provider staff shall document their observation of the Person as specified in the Behavior Support Plan.

(15) Manual restraints shall ensure the Person's safety in breathing and circulation. Manual restraint procedures are limited to the Mandt System (Mandt), the Professional Assault Response Training (PART), or Supports Options and Actions for Respect (SOAR) training programs. Procedures not outlined in the programs listed above may only be used if pre-approved by the State Behavior Review Committee.

(16) Behavior Support Plans that include Manual Restraints shall provide information on the method of restraint, release criteria, and time limitations on use.

R539-4-5. Review and Approval Process.

(1) The Behavior Peer Review Committee shall review and approve the Behavior Support Plan annually. The plan may be implemented prior to the Behavior Peer Review Committee's review; however the review and approval must be completed within 60 calendar days of implementation.

(2) The Behavior Peer Review Committee's review and approval process shall include the following:

(a) A confirmation that appropriate Positive Behavior Supports, including Level I Interventions, were fully implemented and revised as needed prior to the implementation of Level II or Level III Interventions.

(b) Ensure the technical adequacy of the Functional Behavior Assessment and Behavior Support Plan based on principles from the fields of Positive Behavior Supports and applied behavior analysis.

(c) Ensure plans are in place to attempt reducing the use of intrusive interventions.

(d) Ensure that staff training and plan implementation are adequate.

(3) The Provider Human Rights Committee shall approve Behavior Support Plans with Level II and Level III Interventions annually. Review and approval shall focus on rights issues, including consent and justification for the use of intrusive interventions.

(4) The State Behavior Review Committee must consist of at least three members, including representatives from the Division, Provider, and an independent professional having a recognized expertise in Positive Behavior Supports. The Committee shall review and approve the following:

(a) Behavior Support Plans that include Time-out Rooms, Mechanical Restraints or Highly Noxious Stimuli.

(b) Behavior Support Plans that include forms of Manual Restraint or Exclusionary Time-out used for long-term behavior change and not used in response to an emergency situation.

(c) Behavior Support Plans that include manual restraint not outlined in Mandt, PART or SOAR training programs.

(5) The Committee shall determine the time-frame for follow-up review.

(6) Behavior Support Plans shall be submitted to the Division's state office for temporary approval prior to implementation pending the State Behavior Review Committee's review of the plan.

(7) Families participating in Self-Administered Services may seek State Behavior Review Committee recommendations, if desired.

R539-4-6. Emergency Behavior Interventions.

(1) Emergency Behavior Interventions may be necessary to prevent clear and imminent threat of injury or property destruction during emergency situations.

(2) Level I Interventions shall be used first in emergency situations, if possible.

(3) The least intrusive Level II Interventions shall be used in emergency situations. The length of time in which the intervention is implemented shall be limited to the minimum amount of time required to resolve the immediate emergency situation.

(4) Each use of Emergency Behavior Interventions and a complete Emergency Behavior Intervention Review shall be documented by the Provider

on Division Form 1-8 and forwarded to the Division, as outlined in the Provider's Service Contract with the Division.

(a) The Emergency Behavior Intervention Review shall be conducted by the Provider supervisor or specialist and staff involved with the Emergency Behavior Intervention. The review shall include the following:

(i) The circumstances leading up to and following the problem.

(ii) If the Emergency Behavior Intervention was justified.

(iii) Recommendations for how to prevent future occurrences, if applicable.

(5) The Person's Support Coordinator shall review Form 1-8 received from Providers and document the follow-up action.

(6) If Emergency Behavior Interventions are used three times, or for a total of 25 minutes, within 30 calendar days, the Team shall meet within ten business days of the date the above criteria are met to review the interventions and determine if:

(a) A Behavior Support Plan is needed;

(b) Level II or III Interventions are required in the Behavior Support Plan;

(c) Technical assistance is needed;

(d) Arrangements should be made with other agencies to prevent or respond to future crisis situations; or

(e) Other solutions can be identified to prevent future use of Emergency Behavior Interventions.

(7) The Provider's Human Rights Committee shall review each use of Emergency Behavior Interventions.

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:

The SMA reviews incident reports of participants in the review sample that pertain to the use of restraints or seclusion. The SMA also reviews participant records and conducts interviews with providers and participants to determine if all incidents of restraints or seclusion have been reported and appropriately administered. Behavior support plans are also reviewed to determine if the use of restraints or seclusion have been appropriately addressed in the plan including safeguards that address the health and welfare of the participant and that human rights committees have appropriately reviewed and approved the use of restraints or seclusion. The reviews are conducted, at a minimum, every five years. The sample size for each review will be sufficient to

provide a confidence level equal to 95% and a confidence interval equal to 5.

The Operating Agency has the day to day responsibility to assure that appropriate procedures are followed regarding the implementation of the use of restraints and seclusion. All use of restraint and time-out rooms are recorded on incident reports and are reviewed at least monthly by support coordinators. The Human Rights Committee reviews all emergency restraint use. All programmatic use of restraint and time-out is reviewed and approved annually by the participant's team, Behavior Peer Review, and Human Rights Committee. All programmatic use of restraint and time-out rooms are also summarized in provider's Behavior Consultation Service Progress Notes and reviewed at least monthly by support coordinators. State Quality Management and State Behavior Specialist will review data at least annually.

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:
X	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.

Utah Administrative Rules describe the use of Restrictive Interventions and describe the safeguards in place to protect participants when restrictive interventions are used, including:

R539-3-10. Prohibited Procedures.

(1) The following procedures are prohibited for Division staff and Providers, including staff hired for Self-Administered Services, in all circumstances in supporting Persons receiving Division funding:

(a) Physical punishment, such as slapping, hitting, and pinching.

(b) Demeaning speech to a Person that ridicules or is abusive.

(c) Locked confinement in a room. [definition of seclusion]

(d) Denial or restriction of access to assistive technology devices, except where removal prevents injury to self, others, or property as outlined in Sections R539-3-6 and R539-4-7.

(e) Withholding or denial of meals, or other supports for biological needs, as a consequence or punishment for problems.

(f) Any Level II or Level III Intervention, as defined in R539-4-3(n) and R539-4-3(o), used as coercion, as convenience to staff, or in retaliation.

(g) Any procedure in violation of R495-876, R512-202, R510-302, 62A-3-301 thru 62A-3-321, and 62A-4a- 402 thru 62A-4a-412 prohibiting abuse.

R539-4-4. Levels of Behavior Interventions.

(2) All Behavior Support Plans shall be implemented only after the Person or Guardian gives consent and the Behavior Support Plan is approved by the Team.

(3) All Behavior Support Plans shall incorporate Positive Behavior Supports with the least intrusive, effective treatment designed to assist the Person in acquiring and maintaining skills, and preventing problems.

(4) Behavior Support Plans must:

(a) Be based on a Functional Behavior Assessment.

(b) Focus on prevention and teach replacement behaviors.

(c) Include planned responses to problems.

(d) Outline a data collection system for evaluating the effectiveness of the plan.

(5) All Provider staff involved in implementing procedures outlined in the Behavior Support Plan shall be trained and demonstrate competency prior to implementing the plan.

(a) Completion of training shall be documented by the Provider.

(b) The Behavior Support Plan shall be available to all staff involved in implementing or supervising the plan.

(8) Level II Interventions may be used in pre-approved Behavior Support Plans or emergency situations. [Includes manual restraint].

(9) Level III Interventions may only be used in pre-approved Behavior Support Plans. [Includes mechanical restraint and seclusion (time-out room)].

(10) Behavior Support Plans that utilize Level II or Level III Interventions shall be implemented only after Positive Behavior Supports, including Level I Interventions, are fully implemented and shown to be ineffective. A rationale on the necessity for the use of intrusive procedures shall be included in the Behavior Support Plan.

(11) Time-out Rooms shall be designed to protect Persons from hazardous conditions, including sharp corners and objects, uncovered light fixtures, and unprotected electrical outlets. The rooms shall have adequate lighting and ventilation.

(a) Doors to the Time-out Room may be held shut by Provider staff, but not locked at any time.

(b) Persons shall remain in Time-out Rooms no more than 2 hours per occurrence.

(c) Provider staff shall monitor Persons in a Time-out Room visually and auditorially on a continual basis. Staff shall document ongoing observation of the Person while in the Time-out Room at least every fifteen minutes.

(12) Time-out Rooms shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.

(a) Persons shall be placed in the Time-out Room immediately following a

previously identified problem. Time delays are not allowed.

(b) Persons shall not be transported to another location for placement in a Time-out Room.

(c) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria.

(13) Mechanical restraints shall ensure the Person's safety in breathing, circulation, and prevent skin irritation.

(a) Persons shall be placed in Mechanical Restraints immediately following the identified problem. Time delays are not allowed.

(b) Persons shall not be transported to another location for Mechanical Restraints.

(14) Mechanical Restraints shall be used only upon the occurrence of problems previously identified in the Behavior Support Plan.

(a) Behavior Support Plans must outline specific release criteria that may include time and behavior components. Time asleep must count toward time-release criteria. The plan shall also specify maximum time limits for single application and multiple use.

(b) Behavior Support Plans shall include specific requirements for monitoring the Person, before, during, and after application of the restraint to ensure health and safety.

(c) Provider staff shall document their observation of the Person as specified in the Behavior Support Plan.

(15) Manual restraints shall ensure the Person's safety in breathing and circulation. Manual restraint procedures are limited to the Mandt System (Mandt), the Professional Assault Response Training (PART), or Supports Options and Actions for Respect (SOAR) training programs. Procedures not outlined in the programs listed above may only be used if pre-approved by the State Behavior Review Committee.

(16) Behavior Support Plans that include Manual Restraints shall provide information on the method of restraint, release criteria, and time limitations on use.

R539-4-5. Review and Approval Process.

(1) The Behavior Peer Review Committee shall review and approve the Behavior Support Plan annually. The plan may be implemented prior to the Behavior Peer Review Committee's review; however the review and approval

must be completed within 60 calendar days of implementation.

(2) The Behavior Peer Review Committee's review and approval process shall include the following:

(a) A confirmation that appropriate Positive Behavior Supports, including Level I Interventions, were fully implemented and revised as needed prior to the implementation of Level II or Level III Interventions.

(b) Ensure the technical adequacy of the Functional Behavior Assessment and Behavior Support Plan based on principles from the fields of Positive Behavior Supports and applied behavior analysis.

(c) Ensure plans are in place to attempt reducing the use of intrusive interventions.

(d) Ensure that staff training and plan implementation are adequate.

(3) The Provider Human Rights Committee shall approve Behavior Support Plans with Level II and Level III Interventions annually. Review and approval shall focus on rights issues, including consent and justification for the use of intrusive interventions.

(4) The State Behavior Review Committee must consist of at least three members, including representatives from the Division, Provider, and an independent professional having a recognized expertise in Positive Behavior Supports. The Committee shall review and approve the following:

(a) Behavior Support Plans that include Time-out Rooms, Mechanical Restraints or Highly Noxious Stimuli.

(b) Behavior Support Plans that include forms of Manual Restraint or Exclusionary Time-out used for long-term behavior change and not used in response to an emergency situation.

(c) Behavior Support Plans that include manual restraint not outlined in Mandt, PART or SOAR training programs.

(5) The Committee shall determine the time-frame for follow-up review.

(6) Behavior Support Plans shall be submitted to the Division's state office for temporary approval prior to implementation pending the State Behavior Review Committee's review of the plan.

(7) Families participating in Self-Administered Services may seek State Behavior Review Committee recommendations, if desired.

R539-4-6. Emergency Behavior Interventions.

(1) Emergency Behavior Interventions may be necessary to prevent clear

and imminent threat of injury or property destruction during emergency situations.

(2) Level I Interventions shall be used first in emergency situations, if possible.

(3) The least intrusive Level II Interventions shall be used in emergency situations. The length of time in which the intervention is implemented shall be limited to the minimum amount of time required to resolve the immediate emergency situation.

(4) Each use of Emergency Behavior Interventions and a complete Emergency Behavior Intervention Review shall be documented by the Provider on Division Form 1-8 and forwarded to the Division, as outlined in the Provider's Service Contract with the Division.

(a) The Emergency Behavior Intervention Review shall be conducted by the Provider supervisor or specialist and staff involved with the Emergency Behavior Intervention. The review shall include the following:

(i) The circumstances leading up to and following the problem.

(ii) If the Emergency Behavior Intervention was justified.

(iii) Recommendations for how to prevent future occurrences, if applicable.

(5) The Person's Support Coordinator shall review Form 1-8 received from Providers and document the follow-up action.

(6) If Emergency Behavior Interventions are used three times, or for a total of 25 minutes, within 30 calendar days, the Team shall meet within ten business days of the date the above criteria are met to review the interventions and determine if:

(a) A Behavior Support Plan is needed;

(b) Level II or III Interventions are required in the Behavior Support Plan;

(c) Technical assistance is needed;

(d) Arrangements should be made with other agencies to prevent or respond to future crisis situations; or

(e) Other solutions can be identified to prevent future use of Emergency Behavior Interventions.

(7) The Provider's Human Rights Committee shall review each use of Emergency Behavior Interventions.

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:

The SMA reviews incident reports of participants in the review sample that pertain to the use of restrictive interventions. The SMA also reviews participant records and conducts interviews with providers and participants to determine if all incidents of restrictive interventions have been reported and appropriately administered. Behavior support plans are also reviewed to determine if the use of restrictive interventions have been appropriately addressed in the plan including safeguards that address the health and welfare of the participant and that human rights committees have appropriately reviewed and approved the use of restrictive interventions. The reviews are conducted, at a minimum, every five years. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

The Operating Agency has the day to day responsibility to assure that appropriate procedures are followed regarding the implementation of the use of restraints and seclusion. All use of emergency Level II intrusive interventions are recorded by providers on incident reports and reviewed at least monthly by support coordinators. The Human Rights Committee reviews all emergency Level II intrusive interventions. All programmatic use of Level II intrusive interventions are reviewed and approved annually by the participant's team, Behavior Peer Review, and Human Rights Committee. All programmatic use of Level II interventions are summarized in provider's Behavior Consultation Services Progress Notes and reviewed at least monthly by support coordinators. State Quality Management and State Behavior Specialist will review data at least annually.

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:

X	**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.

Entities With Responsibility for Monitoring:

1. Providers for the services *Residential Habilitation, Supported Living, Day Supports, Personal Assistance, Professional Medication Monitoring, Respite, and Extended Living Supports*, may have day-to-day ongoing responsibility for monitoring participant medication regimens. Providers must ensure Staff are competent in specific areas of medication assistance that are outlined in the Provider Contract.
2. DSPD performs ongoing monitoring and follow up activities related to medication errors/incidents. DSPD Contract Analysts, Support Coordinators and Supervisors monitor provider staff competency and training requirements.
3. The State Medicaid Agency (SMA) has ongoing authority and responsibility to oversee and monitor medication incidents and serious issues. The SMA conducts Quality Assurance Reviews to evaluate provider performance measures related to medications. The SMA reviews and approves medication monitoring policies and procedures developed by DSPD.

Methods for Conducting Monitoring:

1. Providers are required to train all applicable staff in medication assistance procedures. Training records are maintained to verify compliance. Providers are required to perform quality assurance activities and improvements which may include medication record reviews.
2. DSPD certifies new providers before contracting for services. Medication training and competency is part of the certification process. DSPD also conducts annual contract reviews to verify provider compliance with medication training and competency. The DSPD Quality Assurance Team conducts ad hoc monitoring of providers to ensure competency. Psychotropic medications, which require a Psychotropic Medication Plan, are monitored through the DSPD Human Rights Committee. The committee determines appropriateness of the Psychotropic Medication Plan, and reviews any human rights restrictions.
3. The SMA conducts Quality Assurance Reviews which include Performance

Measures to monitor provider compliance with medication management, including psychotropic medications. When adverse practices are discovered, a remediation is cited in the review which requires DSPD to provide a plan of correction.

Frequency of Monitoring:

1. Providers must train all new staff in medication competencies within 30 days of employment. The provider and provider's staff must demonstrate medication competency as stated in the contractual agreement.
2. DSPD contract reviews are completed annually for each provider. Medication competency is reviewed as part of this process. The DSPD Quality Assurance Team conducts ad hoc reviews for a percentage of providers on an annual basis to review medication competency. The DSPD Human Rights Committee hears appeals for behavior modifying medication issues as they arise. The Support coordinators review any Psychotropic Medication Plans and Human Rights Policies with participants annually.
3. The SMA conducts Quality Assurance Reviews at a minimum of every two years to determine compliance with medication. The SMA also responds to serious complaints or incidents that may involve medication issues on an on-going basis.

Scope of monitoring:

1. All participants' health and medication needs are reviewed annually by the support coordinator, providers, participant, family, and any other support team members, as part of the Person Centered Planning Process.
2. Participants who are prescribed psychotropic medications as part of their treatment have their plan reviewed annually by the provider, as a member of the participant's planning team.
3. Participants that require testing and nursing services necessary to provide medication management may receive the *Professional Medication Monitoring Service* which includes regularly scheduled periodic visits by a nurse.

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.

Methods used to ensure participant medications are managed appropriately

(a.) the identification of potentially harmful practices:

- Providers perform ongoing monitoring of self –directed self –administrated medication management by showing compliance with the contractual agreement of staff medication competencies.
- DSPD places a contractual obligation on its providers who participate in the supervised self-directed self-administration of waiver enrollee medications to utilize "blister-pack" medication packaging from licensed pharmacies whenever possible. The licensed pharmacy plays a role in monitoring medications for potentially harmful practices.
- Periodic monitoring of participant health and welfare is performed by the support coordinator.

- DSPD contract analyst reviews staff medication competencies annually.
- DSPD Quality Assurance compiles and analyzes incident report data that includes medication errors.
- The SMA conducts Quality Assurance Reviews which include medication performance measures.

(b.) The method for following up on potentially harmful practices

- Notification of incidents (including medication errors) is required per contractual agreement to be submitted by the Provider to the DSPD support coordinator within 24 hours. A written incident report must be submitted within 5 days.
- Each participant's record must contain a list of possible reactions and precautions for medications.
- The Provider must notify a licensed health care professional when medication errors occur.
- Medication errors must be incorporated into the QA process for that provider.
- Training is provided per Provider Contract on: types of errors to report, who to report errors to and how errors are followed up.

(c.) The State agency that is responsible for follow up and oversight.

- Providers are contractually obligated to furnish incident reports to DSPD regarding medication errors and these reports are reviewed by both the Division's Quality Assurance Team as well as the Division Leadership Team.
- The SMA receives an annual Incident Report Summary from DSPD which include an analysis of medication errors by Providers.

c. Medication Administration by Waiver Providers

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

X	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).

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

X	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:
	All medication errors are reported to the Division of Services for People with Disabilities Medication errors considered to be critical incidents are reported to the SMA.
	(b) Specify the types of medication errors that providers are required to *record:*
	Providers must record medication error including: wrong dose, wrong time, wrong route, and wrong medication or missed medication.
	(c) Specify the types of medication errors that providers must *report* to the State:
	Any Medication error that occurs will be reported on an incident report form and will be reported to the support coordinator and the provider director or designee, The employee must notify the support coordinator and representative within 24 hours of the development of any apparent medical need for the person Medication overdoses or medication errors reasonably requiring medical intervention much be reported to DSPD by the provider within 24 hours
○	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:

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.

DSPD compiles an annual incident report which includes medication errors reported by providers.

DSPD Contract Analyst reviews each provider on an annual basis, identifies problems with medication management and requires follow-up remediation actions and quality improvement activities if the problem is systemic.

The DSPD Quality Assurance team performs Ad Hoc reviews that may identify medication management problems, which require follow-up by the provider and incorporation into their quality assurance program.

The SMA receives the findings from the above monitoring activities on an on-going basis and as an annual report.

The SMA has established an on-going Critical Incident Notification system that requires DSPD to notify the SMA of any serious incidents.

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**	**Referrals are made to Adult Protective Services according to State law.**		
Data Source ***DSPD Records*** ***Participant Records*** ***Incident Reports*** ***DSPD Annual Incident Report*** ***Participant Interviews (PES)*** ***Provider Records*** ***Provider Interviews***	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*

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

Performance Measure: #2	**Prevention strategies are developed and implemented (when applicable) when abuse, neglect or exploitation is identified.**		
Data Source ***Participant Records*** ***Provider Interviews*** ***Participant Interviews (PES)*** ***PCSP***	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*

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

Performance Measure: #3	**Within 24 hours of any incident requiring a report, provider notified the Support Coordinator by phone, email or fax.**		
Data Source ***Participant Records*** ***Incident Reports*** ***Provider Interviews*** ***Provider 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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence*

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

Performance Measure: #4	**Within 5 business days of the occurrence of an incident, providers completed Form 1-8 and filed it with the support coordinator.**		
Data Source ***Participant Records*** ***Incident Reports***	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and*	☐ *Stratified:*

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

***Performance Measure:* #5**	**Support coordinator follows up on incident reports with providers to put effective safeguards and interventions in place and verifies this has been accomplished during face to face visits.**		
Data Source ***Participant Records*** ***Participant Service Plans*** ***Participant Interviews (PES)*** ***Provider Interviews***	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative*

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

Performance Measure: #6	**Participants have assistance, when needed, to take their medications.**		
Data Source ***Participant Interviews (PES)*** ***Provider Interviews*** ***Incident Reports*** ***DSPD 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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence*

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

Performance Measure: #7	**Participants have a clear contact for reporting staffing issues.**		
Data Source Participant Interviews (PES)	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐*100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and*	☐ *Stratified:*

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

Performance Measure: #8	**Back up plans are effective and implemented when necessary.**		
Data Source ***Participant Interviews (PES)*** DSPD 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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		X *Other: Specify:* OA: At a minimum every two years. 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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. 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 according to State laws. Prevention strategies are developed and implemented, when abuse, neglect, or exploitation ore reported. Health and welfare needs are addressed and steps are taken to resolve concerns in a timely manner and are documented in the record. In most cases face to face visits are conducted to verify that concerns are resolved. When a critical incident occurs at a provider location, the provider must notify the support coordinator by phone, email or fax within twenty-four hours of the occurrence. In addition, when an incident occurs at a provider location, providers must document the details of the incident on Form 1-8 and submit this form to the support coordinator within five business days of the occurrence of the incident. The SMA Quality Assurance Team conducts monitoring when notified by DSPD of a critical incident or event. The DSPD State Office Quality Management Team conducts reviews of each provider every other year to assure and evaluate the provider's Quality Improvement Plan, which includes incident reporting and Human Rights Plans. When a fatality occurs, the Fatality Review Committee reviews the death and submits a written report to the DSPD Region director. If follow up is required, DSPD and the Region Director submit a report commenting on the findings and recommendations to the Fatality Review Committee within 15 working days. This report includes an action plan to implement recommended improvements. The DSPD Director is responsible for ensuring the regional recommendations are implemented. The SMA Quality Assurance Team conducts participant and provider interviews every five years. The SMA conducts an annual review of the ABI 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 both DSPD and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to

95% and a confidence interval equal to 5.

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 DSPD and the SMA 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)*
	X *State Medicaid Agency*	☐ *Weekly*
	X *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		X *Other: Specify:* *OA: At a minimum every two years.* *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 Health and Welfare that are currently non-operational.

○	**Yes** *(complete remainder of item)*
X	**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: Quality Improvement Strategy

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

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

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

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

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.

Appendix H-1: Systems Improvement

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.

a.ii.

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

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 DSPD waiver manager, and the DSPD Quality Team, among others. The team will meet to assess the results of the systems design changes. The success of the systems changes will be based on criteria that must be met to determine that the change has been accomplished and also criteria that will determine that the systems change has been sustained or will be sustained. The Quality Improvement Committee will determine the sustainability criteria. Results of system design changes will be communicated to participants and families, providers, agencies and others through the Medicaid Information Bulletin, the ABI Quarterly Newsletter, the DSPD web site, and DSPD Board Meetings.

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 ABI 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 agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted. The State conducts a single audit in conformance with the Single Audit Act of 1984, Public Law 98-502.

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

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

1. Plan, develop and manage an array of services and supports for individuals with disabilities;
2. Contract for services and supports for persons with disabilities;
3. Approve and monitor and conduct certification reviews of approved providers;
4. Act as a Fiscal Agent to receive and disburse funds; and
5. Develop standards and rules for the administration and operation of programs operated by or under contract with the division.

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

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

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

1. All providers participating in this 1915(c) HCBS Waiver must: a) Fulfill the DSPD State contracting requirement as one of the waiver provider qualifications related to compliance with State law, and b) abide by the provision of the State contract to bill through DSPD for services provided.
2. The State Medicaid Agency reimburses DSPD for payments that are made for legitimate Waiver service claims by processing the claims through the MMIS system.
3. The State Medicaid Agency receives from DSPD the State matching funds associated with the Waiver expenditures prior to the State Medicaid Agency's drawing down federal funds.
4. The State Medicaid Agency approves all proposed rules, policies, and other documents related to the 1915(c) waiver prior to adoption by the DSPD policy board.

STATE MEDICAID AGENCY ROLE AND PROVIDER CONTRACT REQUIREMENT

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

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

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

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

Each month the support coordinator reviews the billing statement and a monthly budget report generated by the DSPD Financial Analyst.

INTERAGENCY AGREEMENT FOR OPERATIONS AND ADMINISTRATION OF THE HCBS WAIVER

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

The major components of the agreement are:

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

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: **Financial Accountability**
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**	**Number and percentage of payments in a representative sample paid for services identified on a participant's service plan and in total; do not exceed the participant's annual budget.**		
Data Source • **Participant Claims Data** • **PCSP** • **Participant Budgets**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	**X** *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	X *Representative Sample; Confidence Interval 5*
	☐ *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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. SMA: At a minimum every five years.	

***Performance Measure:* #2**	**Number and percentage of participant claims in a representative sample paid for services that use approved waiver codes and rates.**		
Data Source • **Participant Claims Data** • **PCSP** • **Participant Budgets**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	**X** *Quarterly*	**X** *Representative Sample; Confidence Interval 5*
	☐ *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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *OA: At a minimum every two years.* *SMA: At a minimum every five years.*	

***Performance Measure:* #3**	**Number and percentage of participant claims in a representative sample paid for services that match the providers supporting documentation.**		
Data Source • **Participant Claims Data** • **PCSP** • **Participant Budgets** • **Provider 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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval 5*
	☐ *Other: Specify:*	**X** *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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify: OA: At a minimum*	

		every two years. *SMA: At a minimum every five years.*	

***Performance Measure:* #4**	**Number and percentage of provider financial records in a representative sample maintained according to provider contracts.**		
Data Source • **DSPD Contract Review Reports**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	X *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X *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*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

***Performance Measure:* #5**	**Number and percentage of provider claims submitted and processed through the USSDS in a representative sample match the DSPD**

	claims submitted and processed through the MMIS.		
Data Source • **USSDS claims payment history report** • **MMIS claims payment history report**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	**X** *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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *At a minimum every two years.*	

Performance Measure: #6	**Number and percentage of providers in a representative sample receive and retain 100% of amounts claimed for Wavier services.**

Data Source • **USSDS claims payment history report** • **MMIS claims payment history report** • **Provider Claims**	***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)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	**X** *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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *At a minimum every two years.*	

Performance Measure: #7	**Number and percentage of recoupment in a representative sample identified and processed correctly through MMIS with an audit**

State:	
Effective Date	

	trail of the claim paid in error and overpayments are returned to the federal government within 60 days of discovery.		
Data Source • **Participant Claims Data** • **SMA QA Review** • **CMS 64 Report**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	**X** *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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *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 ABI program for each of the five waiver years. Due to available resources, at a minimum one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DSPD and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

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

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.*

Recoupment of Funds:

- When payments are made for services not identified on the PCSP: The Medicaid State Agency will require a recoupment of unauthorized paid claims based upon the Federal Medical Assistance Percentage (FMAP).
- When the amount of payments made exceed the amount identified on the annual budget: The Medicaid State Agency will require a recoupment of unauthorized paid claims based upon the Federal Medical Assistance Percentage (FMAP).
- When payments are made for services based on a coding error: The coding error will be corrected by withdrawing the submission of the claim and submitting the correct code for payment.

The recoupment of funds will proceed as follows:
1. The State Medicaid Agency will complete a Recoupment of Funds Form that indicates the amount of the recoupment and send it to the Operating Agency.
2. The Operating Agency will review the Recoupment of Funds Form and return the signed form to the State Medicaid Agency.
3. Upon receipt of the Recoupment of Funds Form, the State Medicaid Agency will submit the recoupment to Medicaid Operations.
4. Medicaid Operations will reprocess the MMIS claims to reflect the recoupment.
5. Overpayments are returned to the federal government within 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)*
	X *State Medicaid Agency*	☐ *Weekly*
	X *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		X *Other: Specify:* *OA: at a minimum every two years* *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 Financial Accountability that are currently non-operational.

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

There are four principal methods used in setting the DHS Maximum Allowable Rate level. Each method is designed to determine a fair market rate. Four different methodologies are in place to accommodate the different market factors that exist for different types of services. DHS employs the rate setting methodology that best fits the circumstances of a particular service. For example, in this Waiver application, the state has added physical therapy, occupational therapy and speech therapy. Because DHS knows that similar services exist in the Medicaid State Plan, they proposed using the same payment rates used by the Medicaid State Plan. In this case they employed the third methodology, "Comparative Analysis". Had these services been ones that were not paid by Medicaid, but were commonly paid by other payers, then the forth methodology, "Community Price Survey" may have been used. With all new services and any inflationary increases or decreases to existing service rates, the SMA reviews and approves all proposed rates prior to the rates being loaded into the MMIS.

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

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

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

2. Component Cost Analysis

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

3. Comparative Analysis

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

4. Community Price Survey

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

The State solicited public comment during the drafting of the waiver renewal application. The State Medicaid Agency and the Division of Services for People with Disabilities completed the initial draft application August, 2008. The revised draft was submitted to a broad network of consumers, advocates, providers and Tribal Governments and the Medical Care Advisory Committee (MCAC) and the Division of Services for People with Disabilities Board. The entities were sent an electronic copy of the application and were asked to disseminate copies broadly. Entities had 30 days in which to submit comments or questions about all aspects of the ABI Waiver Application.

Payment rates are made available to participants so that they can make informed choices regarding their self administered services in two ways. One: Support coordinators provide payment rate information to participants during their enrollment in self administered services. Two: Annually, DSPD sends an approved payment rate letter to the FMS providers. The FMS providers then communicate this information to all participants they serve.

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:

Requests for payments from the contracted providers are submitted to the Dept of Human Services/DSPD on form 520; payments are then made to the providers. Dept of Human Services/DSPD submits billing claims to DOH for reimbursement.

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

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.*)
X		**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:

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

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

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.
X	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:
	a) The Waiver services that are not paid through an approved MMIS - Payment for all Waiver services are made through an approved Medicaid Management Information System (MMIS) eventually, but for providers who voluntarily reassign payment to the Department of Human Services (DHS), initially payments for Waiver services are paid to providers through the Department of Human Services (DHS), Unified Social Services Delivery System (USSDS). (b) The process for making such payments and the entity that processes payments- Waiver services providers bill the DHS using a paper claim that is entered into the USSDS system. The USSDS system has edits in place that will deny payment for reasons such as exceeding the maximum allowable number of approved units or maximum allowable rates, etc. Providers are reimbursed by DHS with either a paper check or an electronic funds transfer as per the provider's preference. DHS then submits a tape of all claims paid through the USSDS to the SMA. The claims are then entered into the MMIS for payment. The SMA makes payment to DHS through an IGT. Each claim is individually identifiable at the level of the participant, provider, HCPCS and units of service paid. (c) How an audit trail is maintained for all state and federal funds expended outside the MMIS- The audit trail outside the MMIS is maintained through the USSDS. (d) The basis for the draw of federal funds and claiming of these expenditures on the CMS-64- As stated previously all Waiver service payments are eventually made through an approved Medicaid Management Information System (MMIS) and this is 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.
X	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:
	The DHS/DSPD serves as the governmental entity that pays for Waiver claims for providers who voluntarily reassign payment to DHS and DHS will pay for all services provided by the Waiver when they are delivered by qualified providers according to the service plan. The DSPD obtains all of the claims for payment for services delivered directly from contract providers on the form 520. It reviews the claims for accuracy and all approved claims are paid directly to the providers by DSPD. The DSPD then submits billing claims to the DOH for reimbursement. The DSPD has internal controls in place to assure providers paid through the USSDS system receive payment that is equal to the payment DSPD receives from DOH including a comparison of DOH's MMIS Reference File rates with DSPD's USSDS rates for the same service, as per the DOH rate sheet provided each year. A comparison of MMIS HCPCS code/rate information with corresponding USSDS service code/rate information is implemented and documented via screen prints on a copy of a rate chart spreadsheet. This is completed before the beginning of each fiscal year when rates are generally adjusted, but a periodic review of USSDS to MMIS rates is completed throughout the year. Post rate adjustment billing detail is reviewed closely to ensure the agreed rates are correct on the claims submitted for reimbursement, as is the claims reimbursement detail. The SMA will perform an annual post payment review of claims that are paid to providers through the USSDS. The review will verify that the rates paid to providers through the USSDS are equal to the rates paid to DSPD through the MMIS.
☐	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:*

X	**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.*

X	**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 operating agency or Division of Services for People with Disabilities receives the payment for Case Management.
○	**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*:

X	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:

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:*

X	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:*

X	**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.
	The Department of Human Services is the governmental agency to which reassignment is 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:
X	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

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

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**
X	**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:
	The Division of Services for People with Disabilities (DSPD) that resides within the Department of Human Services receives the appropriated funds. DSPD transfers the funds to the State Medicaid Agency via an Intergovernmental Transfer (IGT). This prepayment transfer is based on estimates for the upcoming quarter and takes place approximately 15 days before each new quarter. At the end of the State fiscal year the State Medicaid Agency will perform a final reconciliation on the matching funds for that year.
☐	**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:
X	**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:*

X	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*).
X	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:

Medicaid reimbursement rates paid to Residential Habilitation providers for habilitation services will be individualized based upon the assessed needs of the individual. The daily rate paid to the Residential Habilitation providers cover only the cost of the habilitation services. The daily Medicaid reimbursement excludes all room and board costs.

Individuals are responsible to pay room and board directly to their landlord and purchase food from their personal income. Individuals having insufficient personal income to cover their entire room and board costs may be assisted by a State funded program in which the Division of Services for People with Disabilities assists individuals in paying these costs.

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:*
X	**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:*

X	**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:*

X	**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)*:			Nursing Home				
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(2010)	$39,722	$4,851	$44,573	$48,800	$4,645	$53,445	$8,872
2(2011)	$40,520	$4,948	$45,468	$49,776	$4,738	$54,514	$9,046
3(2012)	$41,332	$5,047	$46,379	$50,771	$4,833	$55,604	$9,225
4(2013)	$42,157	$5,148	$47,305	$51,787	$4,929	$56,716	$9,411
5(2014)	$42,995	$5,251	$48,246	$52,822	$5,028	$57,850	$9,604

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:
		Nursing Facility	
Year 1	198	198	
Year 2	198	198	
Year 3	198	198	
Year 4 (renewal only)	198	198	
Year 5 (renewal only)	198	198	

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.

Average Length of Stay (LOS) = 320 days
- Used the average annual LOS counts for the past 5 fiscal years (2003 – 2007)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

- All calculations are based off the actual amounts for FY2007, from the 372 report
- Unduplicated client counts were increased each year and the number of users was raised according to the percentage of change.
- Financial Management Services client counts were calculated by allocating 80% to low level and 20% to high level
- Price per unit was increased to FY2009 rates and then increased 2% to start FY2010. Each subsequent year was increased 2%
- Units Per User is the average units per user for FY2007 rounded to the next whole number

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:

- All calculations are based off the actual amounts for FY2007
- Average cost per enrollee was increased by 6% for the first year to account for FY2007-

2009 increases. Each subsequent year was increased 2%
- The state utilizes the MMIS Categories of Service and Provider Type functionality to account for and exclude the costs of prescribed drugs from D'

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- Used actual average nursing home cost per day for fiscal year 2007 (Last complete reporting period) and multiplied by actual PD waiver LOS to get fiscal year 2007 base estimate and the increased by 6% to get Waiver year one (fiscal year 2010).
- Each subsequent year was increased 2%

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- Used actual average nursing home cost per day for fiscal year 2007 (Last complete reporting period) and multiplied by actual PD waiver LOS to get fiscal year 2007 base estimate and the increased by 6% to get Waiver year one (fiscal year 2010).
- Each subsequent year was increased 2%

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

X	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**
Behavior Consultation Services I	15 Minute	28	160	$5.42	$24,282
Behavior Consultation Services II	15 Minute	17	160	$9.44	$25,677
Behavior Consultation Services III	15 Minute	13	160	$14.46	$30,077
Chore Services	15 Minute	11	300	$4.23	$13,959
Companion Services	Daily	7	25	$96.16	$16,828
Companion Services	15 Minute	17	2200	$4.01	$149,974
Consumer Preparation Services	15 Minute	25	960	$3.87	$92,880
Day Supports (Site/Non-site) – Hourly	15 Minute	17	1054	$8.62	$154,453
Day Supports (Site/Non-site) – Daily	Daily	17	200	$154.29	$524,586
Environmental Adaptations – Home	Per Episode	17	1	$1,957.62	$33,280
Environmental Adaptations – Vehicle	Per Episode	17	1	$1,618.96	$27,522
Extended Living Supports	15 Minute	8	1416	$3.98	$45,085
Financial Management Services – Low Tier	Monthly	17	12	$31.56	$6,438
Financial Management Services – High Tier	Monthly	17	12	$103.22	$21,057
Homemaker Services	15 Minute	4	300	$4.23	$5,076
Living Start-Up Costs	Per Episode	17	1	$795.28	$13,520
Personal Budget Assistance	15 Minute	17	336	$5.83	$33,301
Personal Budget Assistance	Daily	17	94	$11.66	$18,633
Personal Emergency Response System – Service Fee Monthly	Monthly	14	10	$40.95	$5,733
Personal Emergency Response System – Installation	Per Episode	4	1	$52.50	$210
Personal Emergency Response System – Purchase	Per Episode	4	1	$237.30	$949
Professional Medication Monitoring	Per Episode	17	12	$40.90	$8,344
Residential Habilitation-Facility Based	Daily	21	335	$377.13	$2,653,110

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**
Residential Habilitation- Facility Based – DCFS	Daily	13	335	$138.90	$604,910
Residential Habilitation-Host Home	Daily	7	319	$237.46	$530,248
Residential Habilitation-Host Home – DCFS	Daily	6	319	$101.98	$195,190
Respite Care	15 Minute	8	4000	$2.93	$93,760
Respite Care	Daily	11	85	$68.97	$64,487
Respite Care (Room and Board Included)	Daily	3	20	$77.41	$4,645
Specialized Medical Equipment & Supplies – Monthly	Monthly	7	12	$315.00	$26,460
Specialized Medical Equipment & Supplies – Purchase	Per Episode	7	1	$10,500.00	$73,500
Supported Employment	15 Minute	42	1200	$8.62	$434,448
Supported Employment	Daily	14	204	$35.44	$101,217
Supported Living	15 Minute	143	1350	$5.83	$1,125,482
Transportation – Mileage	Per mile	7	600	$0.38	$1,596
Transportation – Daily	Daily	42	200	$8.67	$72,828
Transportation – Bus Pass Purchase	Per Episode	30	12	$87.68	$31,565
Cognitive Retraining – Speech	Per Session	11	22	$47.23	$11,430
Cognitive Retraining – Ocupational	Per Session	11	19	$21.04	$4,397
Speech Therapy (Extended State Plan)	Per Session	6	27	$47.23	$7,651
Physical Therapy (Extended State Plan)	Per Session	23	27	$21.04	$13,066
Occupational Therapy (Extended State Plan)	Per Session	23	27	$21.04	$13,066
Waiver Support Coordination	Monthly	198	12	$231.51	$550,068
GRAND TOTAL:					$7,864,984
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					198
FACTOR D (Divide grand total by number of participants)					$39,722
AVERAGE LENGTH OF STAY ON THE WAIVER					298

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**
Behavior Consultation Services I	15 Minute	28	160	$5.53	$24,774
Behavior Consultation Services II	15 Minute	17	160	$9.63	$26,194
Behavior Consultation Services III	15 Minute	13	160	$14.75	$30,680
Chore Services	15 Minute	11	300	$4.31	$14,223
Companion Services	Daily	7	25	$98.08	$17,164
Companion Services	15 Minute	17	2200	$4.09	$152,966
Consumer Preparation Services	15 Minute	25	960	$3.95	$94,800
Day Supports (Site/Non-site) – Hourly	15 Minute	17	1054	$8.79	$157,499
Day Supports (Site/Non-site) – Daily	Daily	17	200	$157.38	$535,092
Environmental Adaptations – Home	Per Episode	17	1	$1,996.77	$33,945
Environmental Adaptations – Vehicle	Per Episode	17	1	$1,651.34	$28,073
Extended Living Supports	15 Minute	8	1416	$4.06	$45,992
Financial Management Services – Low Tier	Monthly	17	12	$32.19	$6,567
Financial Management Services – High Tier	Monthly	17	12	$105.28	$21,477
Homemaker Services	15 Minute	4	300	$4.31	$5,172
Living Start-Up Costs	Per Episode	17	1	$811.19	$13,790
Personal Budget Assistance	15 Minute	17	336	$5.95	$33,986
Personal Budget Assistance	Daily	17	94	$11.89	$19,000
Personal Emergency Response System – Service Fee Monthly	Monthly	14	10	$41.77	$5,848
Personal Emergency Response System – Installation	Per Episode	4	1	$53.55	$214
Personal Emergency Response System – Purchase	Per Episode	4	1	$242.05	$968
Professional Medication Monitoring	Per Episode	17	12	$41.72	$8,511
Residential Habilitation-Facility Based	Daily	21	335	$384.67	$2,706,153
Residential Habilitation- Facility Based – DCFS	Daily	13	335	$141.68	$617,016
Residential Habilitation-Host Home	Daily	7	319	$242.21	$540,855
Residential Habilitation-Host Home –	Daily	6	319	$104.02	$199,094

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**
DCFS					
Respite Care	15 Minute	8	4000	$2.99	$95,680
Respite Care	Daily	11	85	$70.35	$65,777
Respite Care (Room and Board Included)	Daily	3	20	$78.96	$4,738
Specialized Medical Equipment & Supplies – Monthly	Monthly	7	12	$321.30	$26,989
Specialized Medical Equipment & Supplies – Purchase	Per Episode	7	1	$10,710.00	$74,970
Supported Employment	15 Minute	42	1200	$8.79	$443,016
Supported Employment	Daily	14	204	$36.15	$103,244
Supported Living	15 Minute	143	1350	$5.95	$1,148,648
Transportation – Mileage	Per mile	7	600	$0.39	$1,638
Transportation – Daily	Daily	42	200	$8.84	$74,256
Transportation – Bus Pass Purchase	Per Episode	30	12	$89.43	$32,195
Cognitive Retraining – Speech	Per Session	11	22	$48.17	$11,657
Cognitive Retraining – Ocupational	Per Session	11	19	$21.46	$4,485
Speech Therapy (Extended State Plan)	Per Session	6	27	$48.17	$7,804
Physical Therapy (Extended State Plan)	Per Session	23	27	$21.46	$13,327
Occupational Therapy (Extended State Plan)	Per Session	23	27	$21.46	$13,327
Waiver Support Coordination	Monthly	198	12	$236.14	$561,069
GRAND TOTAL:					$8,022,873
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					198
FACTOR D (Divide grand total by number of participants)					$40,520
AVERAGE LENGTH OF STAY ON THE WAIVER					298

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**
Behavior Consultation Services I	15 Minute	28	160	$5.64	$25,267

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**
Behavior Consultation Services II	15 Minute	17	160	$9.82	$26,710
Behavior Consultation Services III	15 Minute	13	160	$15.05	$31,304
Chore Services	15 Minute	11	300	$4.40	$14,520
Companion Services	Daily	7	25	$100.04	$17,507
Companion Services	15 Minute	17	2200	$4.17	$155,958
Consumer Preparation Services	15 Minute	25	960	$4.03	$96,720
Day Supports (Site/Non-site) – Hourly	15 Minute	17	1054	$8.97	$160,724
Day Supports (Site/Non-site) – Daily	Daily	17	200	$160.53	$545,802
Environmental Adaptations – Home	Per Episode	17	1	$2,036.71	$34,624
Environmental Adaptations – Vehicle	Per Episode	17	1	$1,684.37	$28,634
Extended Living Supports	15 Minute	8	1416	$4.14	$46,898
Financial Management Services – Low Tier	Monthly	17	12	$32.83	$6,697
Financial Management Services – High Tier	Monthly	17	12	$107.39	$21,908
Homemaker Services	15 Minute	4	300	$4.40	$5,280
Living Start-Up Costs	Per Episode	17	1	$827.41	$14,066
Personal Budget Assistance	15 Minute	17	336	$6.07	$34,672
Personal Budget Assistance	Daily	17	94	$12.13	$19,384
Personal Emergency Response System – Service Fee Monthly	Monthly	14	10	$42.61	$5,965
Personal Emergency Response System – Installation	Per Episode	4	1	$54.62	$218
Personal Emergency Response System – Purchase	Per Episode	4	1	$246.89	$988
Professional Medication Monitoring	Per Episode	17	12	$42.55	$8,680
Residential Habilitation-Facility Based	Daily	21	335	$392.36	$2,760,253
Residential Habilitation- Facility Based – DCFS	Daily	13	335	$144.51	$629,341
Residential Habilitation-Host Home	Daily	7	319	$247.05	$551,663
Residential Habilitation-Host Home – DCFS	Daily	6	319	$106.10	$203,075
Respite Care	15 Minute	8	4000	$3.05	$97,600
Respite Care	Daily	11	85	$71.76	$67,096
Respite Care (Room and Board Included)	Daily	3	20	$80.54	$4,832

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
Specialized Medical Equipment & Supplies – Monthly	Monthly	7	12	$327.73	$27,529
Specialized Medical Equipment & Supplies – Purchase	Per Episode	7	1	$10,924.20	$76,469
Supported Employment	15 Minute	42	1200	$8.97	$452,088
Supported Employment	Daily	14	204	$36.87	$105,301
Supported Living	15 Minute	143	1350	$6.07	$1,171,814
Transportation – Mileage	Per mile	7	600	$0.40	$1,680
Transportation – Daily	Daily	42	200	$9.02	$75,768
Transportation – Bus Pass Purchase	Per Episode	30	12	$91.22	$32,839
Cognitive Retraining – Speech	Per Session	11	22	$49.13	$11,889
Cognitive Retraining – Ocupational	Per Session	11	19	$21.89	$4,575
Speech Therapy (Extended State Plan)	Per Session	6	27	$49.13	$7,959
Physical Therapy (Extended State Plan)	Per Session	23	27	$21.89	$13,594
Occupational Therapy (Extended State Plan)	Per Session	23	27	$21.89	$13,594
Waiver Support Coordination	Monthly	198	12	$240.86	$572,283
GRAND TOTAL:					$8,183,770
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					198
FACTOR D (Divide grand total by number of participants)					$41,332
AVERAGE LENGTH OF STAY ON THE WAIVER					298

Waiver Year: Year 4					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Behavior Consultation Services I	15 Minute	28	160	$5.75	$25,760
Behavior Consultation Services II	15 Minute	17	160	$10.02	$27,254
Behavior Consultation Services III	15 Minute	13	160	$15.35	$31,928
Chore Services	15 Minute	11	300	$4.49	$14,817
Companion Services	Daily	7	25	$102.04	$17,857
Companion Services	15 Minute	17	2200	$4.25	$158,950

State:	
Effective Date	

Waiver Year: Year 4					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Consumer Preparation Services	15 Minute	25	960	$4.11	$98,640
Day Supports (Site/Non-site) – Hourly	15 Minute	17	1054	$9.15	$163,950
Day Supports (Site/Non-site) – Daily	Daily	17	200	$163.74	$556,716
Environmental Adaptations – Home	Per Episode	17	1	$2,077.44	$35,316
Environmental Adaptations – Vehicle	Per Episode	17	1	$1,718.06	$29,207
Extended Living Supports	15 Minute	8	1416	$4.22	$47,804
Financial Management Services – Low Tier	Monthly	17	12	$33.49	$6,832
Financial Management Services – High Tier	Monthly	17	12	$109.54	$22,346
Homemaker Services	15 Minute	4	300	$4.49	$5,388
Living Start-Up Costs	Per Episode	17	1	$843.96	$14,347
Personal Budget Assistance	15 Minute	17	336	$6.19	$35,357
Personal Budget Assistance	Daily	17	94	$12.37	$19,767
Personal Emergency Response System – Service Fee Monthly	Monthly	14	10	$43.46	$6,084
Personal Emergency Response System – Installation	Per Episode	4	1	$55.71	$223
Personal Emergency Response System – Purchase	Per Episode	4	1	$251.83	$1,007
Professional Medication Monitoring	Per Episode	17	12	$43.40	$8,854
Residential Habilitation-Facility Based	Daily	21	335	$400.21	$2,815,477
Residential Habilitation- Facility Based – DCFS	Daily	13	335	$147.40	$641,927
Residential Habilitation-Host Home	Daily	7	319	$251.99	$562,694
Residential Habilitation-Host Home – DCFS	Daily	6	319	$108.22	$207,133
Respite Care	15 Minute	8	4000	$3.11	$99,520
Respite Care	Daily	11	85	$73.20	$68,442
Respite Care (Room and Board Included)	Daily	3	20	$82.15	$4,929
Specialized Medical Equipment & Supplies – Monthly	Monthly	7	12	$334.28	$28,080
Specialized Medical Equipment & Supplies – Purchase	Per Episode	7	1	$11,142.68	$77,999
Supported Employment	15 Minute	42	1200	$9.15	$461,160
Supported Employment	Daily	14	204	$37.61	$107,414

State:	
Effective Date	

Waiver Year: Year 4					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Supported Living	15 Minute	143	1350	$6.19	$1,194,980
Transportation – Mileage	Per mile	7	600	$0.41	$1,722
Transportation – Daily	Daily	42	200	$9.20	$77,280
Transportation – Bus Pass Purchase	Per Episode	30	12	$93.04	$33,494
Cognitive Retraining – Speech	Per Session	11	22	$50.11	$12,127
Cognitive Retraining – Ocupational	Per Session	11	19	$22.33	$4,667
Speech Therapy (Extended State Plan)	Per Session	6	27	$50.11	$8,118
Physical Therapy (Extended State Plan)	Per Session	23	27	$22.33	$13,867
Occupational Therapy (Extended State Plan)	Per Session	23	27	$22.33	$13,867
Waiver Support Coordination	Monthly	198	12	$245.68	$583,736
GRAND TOTAL:					$8,347,037
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					198
FACTOR D (Divide grand total by number of participants)					$42,157
AVERAGE LENGTH OF STAY ON THE WAIVER					298

Waiver Year: Year 5					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Behavior Consultation Services I	15 Minute	28	160	$5.87	$26,298
Behavior Consultation Services II	15 Minute	17	160	$10.22	$27,798
Behavior Consultation Services III	15 Minute	13	160	$15.66	$32,573
Chore Services	15 Minute	11	300	$4.58	$15,114
Companion Services	Daily	7	25	$104.08	$18,214
Companion Services	15 Minute	17	2200	$4.34	$162,316
Consumer Preparation Services	15 Minute	25	960	$4.19	$100,560
Day Supports (Site/Non-site) – Hourly	15 Minute	17	1054	$9.33	$167,175
Day Supports (Site/Non-site) – Daily	Daily	17	200	$167.01	$567,834
Environmental Adaptations – Home	Per Episode	17	1	$2,118.99	$36,023
Environmental Adaptations – Vehicle	Per Episode	17	1	$1,752.42	$29,791

Waiver Year: Year 5					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Extended Living Supports	15 Minute	8	1416	$4.30	$48,710
Financial Management Services – Low Tier	Monthly	17	12	$34.16	$6,969
Financial Management Services – High Tier	Monthly	17	12	$111.73	$22,793
Homemaker Services	15 Minute	4	300	$4.58	$5,496
Living Start-Up Costs	Per Episode	17	1	$860.84	$14,634
Personal Budget Assistance	15 Minute	17	336	$6.31	$36,043
Personal Budget Assistance	Daily	17	94	$12.62	$20,167
Personal Emergency Response System – Service Fee Monthly	Monthly	14	10	$44.33	$6,206
Personal Emergency Response System – Installation	Per Episode	4	1	$56.82	$227
Personal Emergency Response System – Purchase	Per Episode	4	1	$256.87	$1,027
Professional Medication Monitoring	Per Episode	17	12	$44.27	$9,031
Residential Habilitation-Facility Based	Daily	21	335	$408.21	$2,871,757
Residential Habilitation- Facility Based – DCFS	Daily	13	335	$150.35	$654,774
Residential Habilitation-Host Home	Daily	7	319	$257.03	$573,948
Residential Habilitation-Host Home – DCFS	Daily	6	319	$110.38	$211,267
Respite Care	15 Minute	8	4000	$3.17	$101,440
Respite Care	Daily	11	85	$74.66	$69,807
Respite Care (Room and Board Included)	Daily	3	20	$83.79	$5,027
Specialized Medical Equipment & Supplies – Monthly	Monthly	7	12	$340.97	$28,641
Specialized Medical Equipment & Supplies – Purchase	Per Episode	7	1	$11,365.53	$79,559
Supported Employment	15 Minute	42	1200	$9.33	$470,232
Supported Employment	Daily	14	204	$38.36	$109,556
Supported Living	15 Minute	143	1350	$6.31	$1,218,146
Transportation – Mileage	Per mile	7	600	$0.42	$1,764
Transportation – Daily	Daily	42	200	$9.38	$78,792
Transportation – Bus Pass Purchase	Per Episode	30	12	$94.90	$34,164
Cognitive Retraining – Speech	Per Session	11	22	$51.11	$12,369

Waiver Year: Year 5					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Cognitive Retraining – Ocupational	Per Session	11	19	$22.78	$4,761
Speech Therapy (Extended State Plan)	Per Session	6	27	$51.11	$8,280
Physical Therapy (Extended State Plan)	Per Session	23	27	$22.78	$14,146
Occupational Therapy (Extended State Plan)	Per Session	23	27	$22.78	$14,146
Waiver Support Coordination	Monthly	198	12	$250.59	$595,402
GRAND TOTAL:					$8,512,979
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					198
FACTOR D (Divide grand total by number of participants)					$42,995
AVERAGE LENGTH OF STAY ON THE WAIVER					298

State:	
Effective Date	

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year.

Waiver Year: Year 1						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 2						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 3						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 4 (Renewal Only)						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 5 (Renewal Only)						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						