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, 2010): The Department of Human Services (DHS) Division of Services for People with Disabilities (DSPD) is the state agency with statutory authority to provide services to people with disabilities and is the agency that receives the state general funds for the provision of these services. As such, the state has listed eligibility for DSPD services as one of the eligibility requirements of the waiver. Language has been added to this renewal to describe that appeals specifically related to establishing eligibility for State matching funds through DSPD will be heard at the Department of Human Services. Decisions made through the Department of Human Services hearing process, on the question of DSPD eligibility, may be appealed to the Department of Health strictly for procedural review. Appealed decisions, which demonstrate that the Department of Human Services followed the fair hearing process will be upheld by the Department of Health as the final decision. The current application keeps a previous restriction in place which prevents children in the custody of the Utah Department of Human Services: Division of Children and Family services from receiving Respite Care-Weekly services. However, a new exception will now remove this restriction for specialized therapeutic respite camps. 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. Although Appendix K (Emergency Preparedness) is not included as a section in the online 3.5 application, the state intends Appendix K, approved March 1, 2010, to be considered part of the waiver application submission. The state understands that

Appendix K is time limited and will amend the waiver if needed in the future for another purpose.

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 as an alternative to institutional services. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services compliment 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*): Community Supports Waiver (CSW) for Individuals with Intellectual Disabilities and Other Related Conditions

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.*		
O	**Renewal (5 Years) of Waiver #**		
X	**Amendment to Waiver #**	**0158-90.R3.03**	

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
O	Nursing Facility *(select applicable level of care)*	
	O	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
X	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 Community Supports Waiver (CSW) for Individuals with Intellectual Disabilities and Other Related Conditions 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 CSW offers both the agency-based provider model, as well as the self-administered model as the service delivery methods.

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 September, 2009. The Agencies convened a work group consisting of family members, consumers, advocates, providers and state agency representatives to review the initial draft application. Meetings were held in September and October and some amendments to the initial draft were made in response to feedback from the group. The revised draft was submitted to a broad network of consumers, advocates, providers, Tribal Governments and the Medicaid Care Advisory Committee. The entities had 30 days in which to submit comments or questions about the application. The draft was

presented to the Utah Indian Health Advisory Board on January 7, 2010 at which time the Board motioned to accept the proposed changes. The State Medicaid Agency (SMA) will actively solicit public input for a 30 day period immediately prior to all waiver renewal and amendment application submissions.

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

State:	
Effective Date	

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 focused program review conducted annually by the SMA 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 SMA Quality Assurance Team conducts follow up activities to ensure that corrections are sustaining.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the 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	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**	**Number and percentage of DSPD annual reports specified in the implementation plan that were submitted to the SMA on time and in the correct format.**		
Data Source • **DSPD Annual 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*	**X** *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation	***Responsible Party for data aggregation and***	***Frequency of data aggregation and***	

and Analysis	***analysis*** *(check each that applies*	***analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *At a minimum of two times every five years.*	

Performance Measure: #2	**Number and percentage of Level of Care Determinations completed in time specified in the implementation plan.**		
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)*
	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*	
		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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	

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

***Performance Measure:* #3**	**Number and percentage of proposed documents submitted to and approved by the SMA using the Document Submittal Protocol 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 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:* #4**	**The number and percentage of maximum allowable rates (MARs) for covered Waiver services approved by the SMA.**		
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 Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

***Performance Measure:* #5**	**Number and percentage of critical incidents and events of which DSPD notifies the SMA within 24 hours of occurrence (or next business day) as per SMA protocol.**		
Data Source **Critical**	***Responsible Party for data collection/generation***	***Frequency of data collection/generation:*** *(check each that*	***Sampling Approach*** *(check each that applies)*

Incident/Event Findings Operating	*(check each that applies)*	*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:*	

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 CSW 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 CSW 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, conducts annual quality assurance reviews of the CSW Program, 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 CSW program for each of the five

waiver years. At a minimum one comprehensive review will be conducted during this five year cycle. . 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. A response distribution = 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

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

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.*

The SMA contracts with the Department of Human Services for the operation and implementation of the waiver as specified in the State Implementation Plan. The contract requires that DSPD fulfill all requirements stipulated in the implementation plan. When individual issues of non compliance occur the SMA will provide technical assistance including time frames to assure resolution and this will be documented in SMA Reports.

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 –	No Maximum Age Limit
○	**Aged or Disabled, or Both** *(select one)*				
	☐	**Aged or Disabled or Both – General** *(check each that applies)*			
		☐ Aged (age 65 and older)			
		☐ Disabled (Physical) (under age 65)			
		☐ Disabled (Other) (under age 65)			
	☐	**Specific Recognized Subgroups** *(check each that applies)*			
		☐ Brain Injury			☐
		☐ HIV/AIDS			☐
		☐ Medically Fragile			☐
		☐ Technology Dependent			☐
X	**Mental Retardation or Developmental Disability, or Both** *(check each that applies)*				
	X	Autism	0		X
	X	Developmental Disability	0		X
	X	Mental Retardation	0		X
○	**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. Must have a diagnosis of intellectual disability as per 42CFR483.102(b)(3) or a condition closely related to intellectual disability as per 42CFR435.1010.
2. In addition, individuals served in this waiver program must also demonstrate substantial functional limitations in three or more areas of major life activity as described in R414-502-8.
3. Conditions closely related to intellectual disabilities do not include individuals whose functional limitations are due solely to mental illness, substance abuse, personality disorder, hearing impairment, visual impairment, learning disabilities, behavior disorders, physical problems, borderline intellectual functioning, milder autism spectrum disorders, aging process, terminal illnesses, or developmental disabilities that do not result in an intellectual impairment.
4. 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.

5. 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	4666
Year 2	4666
Year 3	4666
Year 4 (renewal only)	4666
Year 5 (renewal only)	4666

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.
O	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.
○	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.
○	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.
○	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 an ICF/ID, or through the CSW. 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 an ICF/ID, or may wait for available capacity in the CSW.

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. However, eligibility for Medicaid is not determined at this time.

While awaiting the availability of CSW services, the operating agency may offer applicants State-funded services such as community supports brokering, referral to other available community resources, and has in the past offered family preservation and supported employment programs that have been entirely State-funded.

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, DSPD has established a Critical Needs Assessment process by which individuals are ranked on a waiting list to prioritize access to 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 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 services through DSPD.

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, 435.301(b)(1)(i)(ii)(iii)(iv), and 435.308)		
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*:		
	1902(a)(10)(A)(i)(IV), (VI), and (VII)		
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):		

State:	
Effective Date	

○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		
○	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:			
	The allowance for the personal needs of the waiver participant is 100% of the HHS Poverty Guidelines for one person plus a disregard for earned income up to the substantial gainful activity level of earnings defined in Section 223(d)(4) of the Compilation of the Social Security Laws in effect April 4, 2012, to determine countable earned income. 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 CFR435.726(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 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. Allowance for the needs of the waiver participant (*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. Allowance for the spouse only (*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. Allowance for the family *(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. Allowance for the personal needs of the waiver participant *(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:		
	The allowance for the personal needs of the waiver participant is: 100% of the HHS Poverty Guidelines for one person plus a disregard for earned income up to the substantial gainful activity level of earnings defined in Section 223(d)(4) of the Compilation of the Social Security Laws in effect April 4, 2012, to determine countable earned income.		
○	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 CFR435.726(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)*:	
	○	The provision of waiver services at least monthly
	X	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:

Waiver Support Coordinator – Certified by DSPD that the person is a qualified QIDP.

Qualified support coordinators shall possess at least a Bachelor degree in nursing, behavioral science or a human services related field such as social work, sociology, special education, rehabilitation counseling or psychology and has at least one year of experience working directly with persons with intellectual disabilities or other developmental disabilities. Support Coordinators must also demonstrate competency relating to the planning and delivery of health services to the waiver population through successful completion of a training program approved by the State Medicaid Agency.

An individual with a “Bachelor degree in a human services related field” means an individual who has received: at least a Bachelor degree from a college or university (master and doctorate degrees are also acceptable) and has received academic credit for a minimum of 20 credit hours of coursework concentration in a human services field, as defined above. Although a variety of degrees may satisfy the requirements, majors such as geology and chemical engineering are not acceptable.

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 414-502-8 defines the State's level of care criteria for intermediate care facilities for persons with intellectual disabilities. The rule defines that a client must:

(1) Have a diagnosis of intellectual disability (42 CFR 483.102(b)(3) or a condition closely related to intellectual disability (42 CFR 435.1010) and

(2) For people seven years old and older, have documented substantial functional limitations in at least three areas of major life activity (self care, receptive and expressive language, learning, mobility, self direction, capacity for independent living, and economic self-sufficiency). Children under the age of seven years old are considered "at risk" for substantial functional limitations due to simply having a diagnosis as described in item (1). Separate documentation to indicate substantial functional limitations in at least three areas of major life activity is not required until a child turns seven years of age.

A variety of histories and evaluations are required for determination of level of care:

(1) Assessments that document functional limitations in three of the major areas of life activity.

(2) Social History and/or Social Summary which has been completed by the applicant or for the applicant no longer than one year prior to the date of application.

(3) Psychological or Special Education Evaluation completed no longer than 5 years prior to the date of original waiver eligibility determination.

(4) Medical Nursing Evaluation which has been completed by a physician or registered nurse longer than one year prior to the date of original eligibility determination. (This form is only required for cases in which the person has specific medical conditions that are complex and/or may require additional services to meet the individual's specific medical needs.

(5) Documentation of date of onset of disability.

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)*:

X	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
○	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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:

A thorough review of available documentation and assessments is conducted initially and annually by specially trained operating agency intake and eligibility personnel. If these personnel determine that the individual meets published eligibility criteria for enrollment in the Home and Community Based Services waiver, that determination is entered in the Level of Care determination screen in the USTEPS system and is electronically signed by the intake and eligibility specialist making that decision, which certifies the annual level of care determination.

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. The Individual's level of care is screened at the time a substantial change in the individual's health status occurs to determine whether the individual has an ongoing need for ICF/ID level of care, this includes at the conclusion of an inpatient stay in a medical institution. A full level of care reevaluation is conducted whenever indicated by a health status change screening and at a minimum within 12 consecutive months of the last recorded level of care determination.

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 DSPD, 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 database 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**	**The number and percentage of level of care evaluations that are conducted for enrollees who meet CSW criteria.**		
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:*	☐ *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.i.b Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

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

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

***Performance Measure:* #1**	**The number and percentage of participant level of care evaluations that are conducted annually.**		
Data Source • **Waiver 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*	
		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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *OA: Annually.* *SMA: At a minimum of two times every five years.*	

Add another Data Source for this performance measure

Performance Measure: #2	**Number and percentage of health status change screenings conducted when a substantial change in health status occurs and/or at the conclusion of an inpatient stay in a medical institution to determine an ongoing need for ICF/ID level of care.**		
Data Source • **Waiver 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*	
		X *Continuously and*	☐ *Stratified:*

		Ongoing	*Describe Groups*
		☐ *Other: Specify:*	
			☐ *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 of two times every five years.*	

***Performance Measure:* #3**	**Number and percentage of full level of care reevaluations conducted when indicated by a health status change screening.**		
Data Source • **Waiver 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*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *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 of two times 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**	**Number and percentage of level of care evaluations and reevaluations conducted by a QIDP certified by DSPD.**		
Data Source • **Waiver 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)*
	☐ *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*	
		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**	**Number and percentage of level of care evaluations and reevaluations documented appropriately in USTEPS.**		
Data Source • **Waiver Participant records** • **USTEPS**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	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*	
		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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *OA: at a minimum every two years.* *SMA: At a minimum of two times every five years.*	

***Performance Measure:* #3**	**Number and percentage of Form 927, "Home and Community-Based Waiver Referral Form" which appropriately document the effective date of the applicant's Medicaid eligibility determination and the effective date of the applicant's level of care eligibility determination.**		
Data Source • **Waiver Participant records** • **Form 927**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =5*
	☐ *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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify: At a minimum, every two 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 critical needs assessment process and placed on the waiting list. When the individual is taken off the waiting list, the CSW Support Coordinator/Intake Worker (QIDP) determines if the individual needs services from the CSW program. For all individuals who have been taken off the waiting list and require services, an initial evaluation for level of care is conducted by the QIDP. DSPD is the entity that will conduct level of care reviews. Findings from the reviews will be submitted to 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. A response distribution = 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

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 regarding the accuracy of level of care determination are addressed and corrected immediately by DSPD to assure that all participants meet ICF/ID level of care. Plans of correction (such as training) may be required to assure future compliance. To assure

all issues have been addressed entities assigned the responsibility of review and remediation are required to report back to the OA or SMA on the results of their interventions within designated time frames. Results of the reviews will be documented in DSPD and SMA Final Reports.

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 of two times 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 818. 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 (ICF/ID) 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 intermediate care facilities for persons with intellectual disabilities and the HCBS Waiver program, is given to each individual applying for waiver services. In addition, individuals will be given a 2-sided Informational Fact Sheet (Form IFS-10) which describes the eligibility criteria and services available through both the waiver program and through ICFs/ID, including contact information for DSPD Intake and for each of the ICFs/ID throughout the state.

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 and the Informational Fact Sheet, 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 Person Centered Support Plan. It is, however, the individual's option to choose institutional (ICF/ID) 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 in writing, 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, who are denied the waiver service(s) and/or waiver provider(s) of their choice, who are found ineligible for the waiver program or who have been notified of actions to suspend, reduce and/or terminate services.

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

The Freedom of Choice Form (Form 818) 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 friends 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	Waiver Support Coordination
Homemaker	X	
Home Health Aide	☐	
Personal Care	X	
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	Routine, Intensive, Weekly, and Group
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 – monthly fee
f.	Personal Emergency Response System – installation and testing
g.	Personal Emergency Response System – purchase
h.	Living Start-Up Costs
i.	Chore Services
j.	Companion Services
k.	Behavior Consultation I, II & III
l.	Extended Living Supports
m.	Personal Budget Assistance
n.	Professional Medication Monitoring
o.	Supported Living
p.	Family Training and Preparation Services
q.	Family and Individual Training and Preparation Services
r.	Financial Management Services
s.	Massage Therapy

Extended State Plan Services *(select one)*	
X	Not applicable
○	The following extended State plan services are provided *(list each extended State plan service by service title)*:

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	Family Training and 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. 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):

	Utah Code (Annotated) 62A-2-121, 122 and R501-14 of the Utah Administrative Code require 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 continued employment or provider payments if the required screenings have not been completed in a timely fashion.
○	**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 a Statement of Interested and Qualifications (SOIQ) for the purpose of entering into a contract with willing and qualified individuals and public or private organizations.

The SOIQ is distributed to all qualified providers 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 SOIQ 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**	**Number and percentage of providers that meet DSPD provider contract criteria.**		
Data Source	***Responsible Party for data***	***Frequency of data collection/generation:***	***Sampling Approach*** *(check each that*

• **Provider records** • **Provider Staff Interviews**	***collection/generation*** *(check each that applies)*	*(check each that applies)*	*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:* #2**	**Number and percentage of newly enrolled providers that have developed a human rights plan in compliance with DSPD standards.**		
Data Source • **Provider Human Rights Plan**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*

	☐ *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: **#3**	**Number and percentage of licensed health care facilities that 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: Bureau of Licensing*	☐ *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *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*	
	☐ *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**	**Number and percentage of Self-Administered Services (SAS) providers who maintain accurate and updated employee files.**		
Data Source • **Employee Files**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *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*	
		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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* At a minimum every two years.	

***Performance Measure:* #2**	**Number and percentage of Self-Administered Services (SAS) providers who complete all appropriate forms.**		
Data Source • **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:*	☐ *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis***	***Frequency of data aggregation and analysis:***	

	(check each that applies	*(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:* #3**	**Number and percentage of Self-Administered Services (SAS) providers who provide appropriate training.**		
Data Source • **Employee Files** • **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:*	☐ *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:*	☐ *Annually*	

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

Performance Measure: #4	**Number and percentage of Self-Administered Services (SAS) providers who bill properly for services.**		
Data Source • **Billing data**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* At a minimum every two years.	

State:	
Effective Date	

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

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

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

***Performance Measure:* #1**	**Number and percentage of provider staff who have 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)*
	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*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other*	
			☐ *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:* #2**	**Number and percentage of CSW Support Coordinators who have completed DSPD core curriculum.**		
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:*	
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.

DSPD conducts annual provider reviews of all programs that provide services to CSW participants. Monitoring includes all criteria specified in the provider contract. The DSPD Quality Management Team conducts Quality Improvement provider reviews. Support coordinators 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 CSW 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 conducts 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. When not 100% the sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5. A response distribution = 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

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 provider issues identified during contract reviews are corrected immediately by the provider or, at a minimum within designated time frames. To assure the issue has been addressed, entities assigned the responsibility of review and remediation are required to report back to the OA or SMA on the results of their interventions within designated time frames. Findings and corrections are documented in DSPD Final Reports.

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: Annually.* *SMA: At a minimum of two times 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 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.

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:	**Waiver Support Coordination**
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)**:**

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. In order to accomplish this, Support Coordinators are afforded access to the individuals that they serve at all times, with or without prior notice.

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 Person Centered Support Plan (PCSP), (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 PCSP.

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 PCSP, (k) instruct the individual/legal representative/family how to independently obtain access to services and supports, regardless of funding source, (l) provide transition planning services when an individual living in an ICF/ID is transitioned to the waiver, (m) provide discharge planning services when an individual is disenrolled from the waiver, and (n) assist individuals to request a fair hearing if an adverse decision has been made regarding waiver eligibility, amount, frequency and duration of waiver services and/or choice of providers from which to receive waiver services.

When a waiver participant elects to enroll in hospice care, support coordinators shall meet together with the hospice case management agency upon commencement of hospice services to develop a coordinated plan of care that clearly defines the roles and responsibilities of each program. The support coordinator shall ensure that the waiver program provides services that are unrelated to the client's terminal illness and are necessary to maintain safe residence in a home or community-based setting in accordance with waiver requirements.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The waiver support coordination service will not duplicate similar services provided by other programs serving children under this waiver including education and foster care, i.e., children in 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)*:		Individual. List types:	X	Agency. List the types of agencies:
			Individual Medicaid 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—Individual Medicaid Provider		Certified by DSPD as a QIDP Support Coordinator.	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 Intellectual Disability Professional (QIDP) as specified in the job specifications contained within: Interpretive Guidelines for ICF for Persons with Intellectual Disabilities (W159-W180); Code of Federal Regulations, Centers for Medicare and Medicaid Services, State Operations Manual – Appendix J, pages 77-87. 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 persons with intellectual impairments or other related conditions through successful completion of a core curriculum and testing program approved by the State Medicaid Agency. An individual with a "Bachelor degree in a human services related field" means an individual who has received: **at least** a Bachelor degree from a college or university

			(master and doctorate degrees are also acceptable) and has received academic credit for a minimum of 20 credit hours of coursework concentration in a human services field, as defined above. Although a variety of degrees may satisfy the requirements, majors such as geology and chemical engineering are not acceptable.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Medicaid Provider	Division of Services for People with Disabilities CSW Support Coordinators are monitored and evaluated on an ongoing basis by: A) their DSPD Program Manager, B) the CSW Program Administrator, 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:	
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)**:**	

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

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.

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 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-- 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:	
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)**:**

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 under the age of 22.
- Host Homes – Supervised Private Residences for 2 or less individuals aged 18 or older.

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, other than such costs for modifications or adaptations to a residence required to assure the health and welfare of residents, 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 individuals in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services. For individuals 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) Professional Parent: Licensed Child Placing Adoption Agencies R501-7-1, 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. 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:	
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)**:**

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.

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. Services rendered for 6 hours or longer in a single day will be paid using the daily rate with the exception of the Day Supports-Partial service which will be paid using the daily rate for services rendered for 10 hours per day or longer during periods of extended school closure.

This service is available to children in the custody of the State of Utah: Department of Human Services,

Division of Child and Family Services but, only when Medicaid is the payer of last resort.				
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 R539-7, 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
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.

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.

Services rendered in excess of six hours in a single day will be paid at the daily rate.

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

State:	
Effective Date	

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

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
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 Care - Routine**

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)**:**

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.

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 appropriate DSPD designee 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, when the need exists and approval has been granted in advance for the utilization of this service by the appropriate DSPD staff. All instances in which Respite Care-Routine services are delivered for a period of six hours or more within a day shall be billed using a daily rate rather than hourly rates for this service.

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.

Respite care may not be offered at the same time as the person is receiving any other service, either contained within this Home and Community-Based Services waiver or from other sources including the Medicaid State Plan that will afford the person with care and supervision. Respite care may not be offered for relief or substitution of staff paid to provide care and supervision to persons as part of the residential or day habilitation services they receive in this Home and Community-Based Services waiver.

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	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

		62A-5-103, UCA.	
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 Nursing Facility: R432-150, UAC Assisted Living Facility: R432-270, 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

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:	**Respite – Routine Group**
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)**:**	
Respite Care- Routine Group is care provided to groups of up to three individuals in a group setting in order to give relief to, or during the absence of, the individuals' normal caregiver(s). 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 employee.	

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 group respite care services that are rendered for a period of six hours or more out of the consumer's private residence in a setting approved by the State, this service will be billed under a specific "Respite Care-Group-Out of the home/Room and Board included" billing code. In the case of services contained within this definition provided in the employee's or the person's home, in no case will more than five (5) individuals be served by the employee at any one time, except that the employee's children over the age of 14 will not be counted toward the limit of five. Individuals receiving services within the Day Supports or Supported Living services may receive Respite Care-Routine-Group 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, when the need exists and approval has been granted in advance for the utilization of this service by the appropriate DSPD designee. All instances in which Respite Care-Routine-Group services are delivered for a period of six hours or more within a day shall be billed using a daily rate rather than hourly rates for this service. 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. Respite care may not be offered at the same time as the person is receiving any other service, either contained within this Home and Community-Based Services waiver or from other sources including the Medicaid State Plan that will afford the person with care and supervision. Respite care may not be offered for relief or substitution of staff paid to provide care and supervision to persons as part of the residential or day habilitation services they receive in this Home and Community-Based Services waiver.

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--	Licensed by the	Certified by DSPD	Under state contract with DSPD as an

Respite	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 Nursing Facility: R432-150, UAC Assisted Living Facility: R432-270, UAC	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. Enrolled as a Medicaid provider

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:	**Respite Care– Intensive**
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)**:**	
Respite Care - Intensive is care provided to give relief to, or during the absence of, the normal caregiver. Intensive level respite care is provided to individuals who have complex conditions that require a level of assistance beyond that which is offered by direct service staff under the definition of Respite Care-Routine. Individuals receiving Respite Care-Intensive Level services will typically present with a more complex array of physical or behavioral needs than those receiving routine respite care services. Services may include hourly, daily and overnight support and may be provided in the individual's place of residence, a facility approved by the State that is not a private residence, or in the private residence of the respite care provider. Respite Care-	

Intensive level services are, because of their more complex nature, delivered by more experienced and sophisticated staff.

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 intensive services that are rendered out of the consumer's private residence in a setting approved by the State, this service will be billed under a specific "Respite Care-Intensive-Out of the home/Room and Board included" billing code. All instances in which Respite Care-Intensive services are delivered for a period of six hours or more within a day shall be billed using a daily rate rather than hourly rates for this service.

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.

Respite care may not be offered at the same time as the person is receiving any other service, either contained within this Home and Community-Based Services waiver or from other sources including the Medicaid State Plan that will afford the person with care and supervision. Respite care may not be offered for relief or substitution of staff paid to provide care and supervision to persons as part of the residential or day habilitation services they receive in this Home and Community-Based Services waiver.

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:	Certified by DSPD as an authorized provider of services and supports to people with disabilities in	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

	Licensed Residential Treatment Programs R501-19, UAC Licensed Residential Support Programs R501-22, UAC Nursing Facility: R432-150, UAC Assisted Living Facility: R432-270, UAC	accordance with 62A-5-103, UCA.	

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:	**Respite Care – Weekly**

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 – Weekly is care rendered on a weekly basis which is provided to relieve, or during the absence of, the normal care giver which is furnished to a covered individual on a short term basis in a facility or other approved community based entity (i.e. a certified facility, temporary care facility, overnight camp, summer programs or a facility providing group respite).

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

Limitations: Respite Care-Weekly shall not be provided in a waiver participant's or immediate family's normal place of residence.

With the exception of specialized therapeutic respite camps, 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)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Respite 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--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 Nursing Facility: R432-150, UAC Assisted Living Facility: R432-270, 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

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)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	**Environmental Adaptations**

State:	
Effective Date	

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)**:**

Environmental Adaptations involve equipment and/or physical adaptations to the individual's residence and/or 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. 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
g. Vehicle adaptations
   1. Lifts
   2. Door modifications
   3. Steering/braking/accelerating/shifting modifications
   4. Seating modifications
   5. 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 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:
				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 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.

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.

Transportation may not be offered to those who receive residential or supported living services that include transportation, as well as to those who receive day supports or supported employment services (specifically customized employment or supported employment–individual or supported employment co-worker that include transportation.

Transportation includes both a per trip rate for the purposes of habilitation in the community as well as a daily rate that provides for transportation to and from organized day-supports or supported employment activities.

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	
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:	
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—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 necessary for the operations of that equipment 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.

Elements of Specialized Medical Equipment & Supplies:
The Specialized Medical Equipment & Supplies category includes elements for purchase and for an ongoing service fee.

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

Limitations: Expenditures for specialized medical equipment and the supplies necessary to operate that equipment will be in accordance with Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and supplies necessary for the operation of that equipment must be approved prior to purchase by a DHS/DSPD Administrative Program Manager based on a determination of medical necessity by a physician or an advanced practice registered nurse with prescriptive privileges 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 Current business license Current business license		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:	
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)**:**

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

State:	
Effective Date	

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

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
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 the case where no other relative, care giver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization. Individuals receiving any other service contained within this waiver that may duplicate the provision of Chore Services are not eligible to

receive Chore Services. This service is not available to foster 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		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**

State:	
Effective Date	

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)**:**

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.

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 DSPD .

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.

Services rendered in excess of 6 hours in a single day will be billed using the daily rate.

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 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--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	Current business license	Certified by DSPD as an authorized	Under state contract with DSPD as an authorized provider of services and supports

Services Provider		provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	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:	**Family and Individual Training and Preparation Service**
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)**:**	

Family and Individual Training and Preparation Service is training and guidance services for covered individual or family member. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, , or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home and to maintain the integrity of the family unit. Training may also include instructions on how to access services, how to participate in the self-direction of care, how to hire, fire and evaluate service providers, consumer choices and rights, consumer's personal responsibilities and liabilities when participating in consumer-directed programs (e.g., billing, reviewing and approving timesheets), instruction to the family, and skills development training to the individual relating to interventions to cope with problems or unique situations occurring within the family, techniques of behavior support, social skills development, and accessing community cultural and recreational activities. Family and Individual Training and Preparation Service is intended for families who present with considerably more complex or dysfunctional issues than those receiving Family Training and Preparation services, and may include families with multiple consumers within the family. Or, families receiving this service have been assessed as requiring a more sophisticated level of training and assistance than those receiving routine Family Training and Preparation services. Services rendered under this service definition are delivered by Bachelors level staff with considerably greater training and experience than those rendering service under the Family Training and Preparation Service definition, including specific topical training in family and individual consultation using a curriculum prepared by DSPD and approved by the SMA, and providers of this service must successfully complete training offered by DSPD utilizing this curriculum.

Services may also include those that enhance the individual's ability to exercise individual rights as a member of society through self-sufficiency and informed decision-making. Supports include: (a) Training in conflict resolution and mediation of disagreements, and forming a consensus (b) Identifying, building, and maintaining natural supports; and, (c) Instructing and consulting with families on ways to become as self-sufficient as possible.

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

Limitations: Services and supports provided through the Family and Individual Training and Preparation Services category are intended to accomplish a clearly defined outcome that is outlined in the individual support plan, including the expected duration of the activity and the measures to be used to gauge progress. The activities will not consist solely of supervision, companionship or observation of the individual during leisure and other community events. Family and Individual Training and Preparation services are not available to foster families. 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)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Family Training and 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)*

State:	
Effective Date	

Agency-based—Family Training and 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
Family and Individual Training and 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 Specification

Service Title:	**Family Training and Preparation 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)**:**

Family Training and Preparation Service is training and guidance services for covered individuals or family members. For purposes of this service, "family" is defined as the persons who live with or provide care to a individual served under the waiver, and may include a parent, spouse, children, relatives, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home and to maintain the integrity of the family unit. Training may also include instructions on how to access services, how to participate in the self-direction of care, how to hire, fire and evaluate service providers, consumer choices and rights, consumer's personal responsibilities and liabilities when receiving services under the self-administered services method (e.g., billing, reviewing and approving timesheets), instruction to the family, and skills development training to the individual relating to interventions to cope with problems or unique situations occurring within the family, techniques of behavior support, social skills development, and accessing community cultural and recreational activities.

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

Limitations: Services and supports provided through the Family Assistance and Support category are intended

to accomplish a clearly defined outcome that is outlined in the individual support plan, including the expected duration of the activity and the measures to be used to gauge progress. The activities will not consist solely of supervision, companionship or observation of the individual during leisure and other community events. Family Training and Preparation services are not available to foster families. 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		Family Training and Preparation Services 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—Family Training and Preparation 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. Must complete a training course prescribed by DSPD and approved by the State Medicaid Agency and must demonstrate competency in related topical area(s) of: (1) Self-determination (2) Natural supports, (3) Instruction and/or consultation with families/siblings on: a) Assisting self sufficiency b) Safety Must be a professional with a bachelor's degree in social or behavioral sciences or a mental health professional with a master's degree in social or behavioral sciences. Completed Provider Agreement
Agency-based—Family Training and Preparation Services Provider	Current business license	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance 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. Must complete a training course prescribed by DSPD and approved by the State

		62A-5-103, UCA.	Medicaid Agency and must demonstrate competency in related topical area(s) of: (1) Self-determination (2) Natural supports, (3) Instruction and/or consultation with families/siblings on: a) Assisting self sufficiency b) Safety Must be a professional with a bachelor's degree in social or behavioral sciences or a mental health professional with a master's degree in social or behavioral sciences. Enrolled as a Medicaid provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Family and Individual Training and Preparation 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 Title:	**Behavior Consultation I**
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)**:**

Behavior Consultation I services include 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 an ICF/ID 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.	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
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 intellectual disabilities or other related conditions 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	**Division of Services for People with**	**Annually**

Consultation Service I Provider	Disabilities	

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 II**
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)**:**

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 an ICF/ID 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 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 intellectual disabilities 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 intellectual disabilities 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

State:	
Effective Date	

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:	
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)**:**

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 an ICF/ID 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 Providers of this service shall meet one of the following three requirements:

			1) Board Certified Behavior Analysts (BCBA); 2) Proof of achievement of a post-graduate degree of a doctoral level in a behaviorally related field and a combination of education, training and experience equivalent to that required for certification as a Board Certified Behavior Analysts; or 3) Licensure as a Psychologist by the State of Utah, successful completion of two semester long graduate courses in behavior analysis, and successful completion of one year of work experience utilizing behavior analysis with people with intellectual disabilities or other related conditions. Enrolled as Medicaid provider
Agency-based--Behavior Consultation Service III 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 Providers of this service shall meet one of the following three requirements: 1) Board Certified Behavior Analysts (BCBA); 2) Proof of achievement of a post-graduate degree of a doctoral level in a behaviorally related field and a combination of education, training and experience equivalent to that required for certification as a Board Certified Behavior Analysts; or 3) Licensure as a Psychologist by the State of Utah, successful completion of two semester long graduate courses in behavior analysis, and successful completion of one year of work experience utilizing behavior analysis with people with intellectual disabilities or other related conditions. 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:	
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)**:**	
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. This service is available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services but, only when Medicaid is the payer of last resort.	

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.
X	Service is included in approved waiver. The service specifications have been modified.
○	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.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Personal Budget Assistance affords those also receiving Financial Management Services (FMS) with assistance in managing their personal funds and budgets and will afford representative payee services for those that are assessed as requiring them, while FMS only provides payroll services for those persons who elect to utilize participant direction.	

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

State:	
Effective Date	

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

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
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 *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

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.
X	Service is included in approved waiver. The service specifications have been modified.
○	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, and is only available after similar services offered through the Medicaid State Plan have been exhausted.

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:	
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 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 and is offered on a year-round basis. 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.

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		Supported Living 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—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—	Current business	Certified by DSPD	Under state contract with DSPD as an

Supported Living	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. 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:	**Massage Therapy**
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)**:**	
Massage Therapy is provision of therapeutic services delivered by licensed massage therapists intended to provide comfort, stress and tension relief and reduction, and other health-related benefits consistent with the practice of massage therapy. This service is intended to accomplish a clearly defined outcome that is outlined in the individual support plan.	
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:
	Licensed Massage Therapist		Massage Therapy Provider	

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

State:	
Effective Date	

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency-based—Massage Therapy	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
Individual Licensed Massage Therapist	Sec. 58-47b, UCA and R156-47b, 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

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Massage Therapy 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 Care**
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 Care is provision on an hourly or daily basis of personal assistance and supportive services, specific to the needs of a medically stable individual who is capable of directing his/her own care or has a surrogate available to direct the care. This service is intended to reinforce an individual's strengths, while substituting or compensation for the absence, loss, diminution, or impairment of physical or cognitive functions. Services will be outlined in the individual support plan and will not duplicate other covered waiver supports.

Personal Care services are provided on a regularly scheduled basis and are available to individuals who live

alone or with roommates. Services may be provided in the recipient's place of residence or in settings outside the place of residence.

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

Individuals receiving any other service contained within this waiver or through the Medicaid State Plan that may duplicate the provision of Personal Care are not eligible to receive Personal Care until such services that are entirely duplicative that are offered through other funding sources such as the Medicaid State Plan are exhausted.

Services rendered in excess of eight hours in a single day will be paid using the daily rate.

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Self-directed personal care services provider		Home Health Agency Personal 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 Care 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.
Agency-Based Personal Care provider	R432-700	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. Enrolled as a Medicaid provider.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Assistance 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 Title:	**Financial Management 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)**:**	
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:	
Financial Management Services are intended to provide payroll services to Home and Community-Based Services waiver participants who elect participant direction. This service is provided to those utilizing Self Administered Services. This service does not provide persons with assistance in managing their personal funds or budgets and does not provide representative payee services.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	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 BACBS as an authorized provider of services and supports.	• Under State contract with BACBS 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 Services for People with Disabilities**	**Upon initial enrollment and annual sampling of waiver providers thereafter.**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	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 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 DSPD Assessment Specialists complete the formal assessment process 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 identifying 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 opportunity 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 CSW 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 and approved by a DSPD Administrative Program Manager. 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 AAIDD's 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.

a) who develops the plan, who participates in the process, and the timing of the plan:

The Support Coordinator has ultimate responsibility to develop the PCSP; however, it is the entire team's responsibility to participate and the developed PCSP is reviewed and approved by a DSPD Administrative Program Manager. 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.

(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:

The CSW utilizes a comprehensive approach to service plan development. The AAIDD's Supports Intensity Scale (SIS) is the primary assessment tool for the development of the Person Centered Support Plan (PCSP), enhanced by a module assessing the level of supervision an individual requires for successful and safe habilitation in their communities as well as a risk assessment module. Other important assessments include: 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 CSW including the definition of each service. In addition, the list of CSW 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 by specially trained DSPD assessment specialists 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 request that the DSPD assessment specialist add these to the assessment. 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 CSW 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 CSW 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 DSPD assessment specialist 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. Other assessments and the results of the past year's supports are also reviewed. During the planning meeting the team reviews items identified as areas of concern. Decisions are made based on the participant's 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 risks 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 Administrative Program Managers, 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 reviews of a representative sample of waiver enrollee's service plans that will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5. A response distribution = 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

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
X	Operating agency
☐	Case manager
☐	Other (*specify):*

Appendix D-2: Service Plan Implementation and Monitoring

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

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

The Support Coordinator ensures that the PCSP is completed and submitted to a DSPD Administrative Program Manager for review and approval prior to implementation. If any interested party believes that the 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, and reviewed and approved by DSPD Administrative Program Managers.

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

1. Regularly scheduled face to face visits with the person (while quarterly face to face visits is the standard, the Support Coordinator has the discretion to conduct face to face visits with the client more frequently than quarterly. 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 of supports and families to ensure that participants are receiving quality supports in the environment of their choice.

In order to accomplish these implementation and monitoring activities, Support Coordinators and officials of the Operating Agency and the SMA are afforded access to the individuals that they serve at all times, with or without prior notice.

Quality assurance monitoring of PCSPs is conducted 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 CSW 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**	**Number and percentage of PCSPs that address all participants' assessed needs including health needs, safety risks and personal goals**

	by the provision of a sufficient amount of covered waiver services and other services including State Plan, generic and natural supports.		
Data Source • **SIS** • **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)*
	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*	
		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:*	☐ *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 participants for whom there is sufficient documentation to ascertain whether participants 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 of two times 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 of two times every five years..*	

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Effective Date	

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**	**Number and percentage of the Supports Intensity Scale (SIS) Assessments administered, at a minimum, every five years**		
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*	
		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*	

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

***Performance Measure:* #2**	**Number and percentage of the SIS updated when the participant's assessed needs change.**		
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 of two times 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*	

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Effective Date	

		☐ *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: 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**	**Number and percentage of PCSPs reviewed and updated at least annually.**		
Data Source • **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)*
	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*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:.*	
			☐ *Other: Describe*
Data Aggregation and	***Responsible Party for***	***Frequency of data***	

Analysis	***data aggregation and analysis*** *(check each that applies*	***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 of two times every five years.*	

Performance Measure: **#2**	**Number and percentage of PCSPs that are updated/revised when warranted by changes in the participant's needs.**		
Data Source • **SIS** • **Participant Records** • **PCSP** • **Claims Data**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	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*	

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		every two years. *SMA: At a minimum of two times 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 of two times 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**	**Number and percentage of PCSPs on which all services delivered are identified and the total amount of services delivered does not exceed the amount authorized.**		
Data Source	***Responsible Party for***	***Frequency of data***	***Sampling Approach***

• **PCSP** • **Claims Data**	***data collection/generation*** *(check each that applies)*	***collection/generation:*** *(check each that applies)*	*(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 of two times 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 of two times 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**	**Number and percentage of participants who are offered the choice of either ICF/ID care or CSW services.**		
Data Source • **Form 818**	***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*	
		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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	

		X *Other: Specify:* *OA: Annually* *SMA: At a minimum of two times every five years.*	

***Performance Measure:* #2**	**Number and percentage of participants who are made aware of all services available on the CSW.**		
Data Source • **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)*
	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*	
		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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *OA: Annually*	

		SMA: At a minimum of two times every five years.	

***Performance Measure:* #3**	**Number and percentage of participants who are offered choice among providers.**		
Data Source • **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)*
	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*	
		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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* *OA: Annually* *SMA: At a minimum of*	

		two times 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 every three years after that. If there have been significant changes, the assessment is updated. All services are identified on the service plan regardless of funding source. Participants are offered choice of either ICF/ID care or CSW services and choice is documented on a DHS/DSPD Form 818. Participants are made aware of all services available on the CSW and are offered choice among providers whenever choice exists. Choice of providers is documented in the participant's record. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5. A response distribution = 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

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 then has the opportunity 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 service plan issues identified by DSPD and the SMA that affect the health and

welfare of individual participants are addressed immediately. To assure the issue has been addressed, entities assigned the responsibility of review and remediation are required to report back to the OA or SMA on the results of their interventions within designated time frames. A description of issues requiring immediate attention and outcomes are documented through the SMA final report. Issues that are less immediate are corrected within designated time frames and are documented through the SMA final review report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained by the SMA. Findings and corrective actions are reported on DSPD and SMA Annual Reports.

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 of two times 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	

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. Family Training and 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 Family Training and 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 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 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 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 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	☐
Respite	X	☐
Supported Living	X	☐
Transportation	X	☐
Family Training and Preparation Services	X	☐
Personal Assistance	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:	
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 requirements, by imposing more stringent record keeping requirements on the Financial Management Services provider. 8. Obtain IRS approval for Agent status. The Financial Management Services provider shall consolidate the federal filing requirements, obtain approval for Utah State Tax Commission consolidated filings, and obtain approval for consolidated filing for unemployment insurance through the Department of Workforce Services. For those Employers retaining domestic help less than 40 hours per week, Workers Compensation coverage is optional. If the 40-hour threshold is achieved or exceeded, the Worker's Compensation Act requires coverage. Statutory requirements and the nature of insurance entail policies on an individual basis. Consolidated filings of Workers Compensation are not an option. 9. Financial Management Services provider cannot provide waiver recipients with community-based services in addition to Financial Management Services.
	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.

DSPD 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, 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 or employees, the support coordinator will order Family Training and 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: **Family Training and 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 Family Training and 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 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 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. Involuntary termination of self-administered services is not a grievable action per Appendix E of the CMS Version 3.5 HCBS Waiver Application Instruction Manual.

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	1200	N/A
Year 2	1200	N/A
Year 3	1200	N/A
Year 4 (renewal only)	1200	N/A
Year 5 (renewal only)	1200	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, Form 522 and a Hearing Request Form 490S from a DSPD administrative program manager, 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 or experiences a denial, reduction, suspension, or termination in waiver services in accordance with R539-2-5. In instances in which an individual is found to be ineligible for entrance to the waiver, they may request an administrative fair hearing from the Depart of Human Services, which is dispositive. The person may request assistance from the Disability Law Center, Utah's statutory protection and advocacy organization, or others rights and advocacy organizations in arranging for and participating in this hearing. Services are not afforded during this period of pendency.

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

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

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

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 provider personnel, etc.

When DSPD receives a Hearing Request Form (490S) a two 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 reached, Division staff arranges a Review meeting between the individual and/or their legal representative and the Director or the Director's designee.

3.

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 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 support coordinator to provide information to waiver participants on the conflict resolution process and on how to contact the Division The Division reviews all complaints submitted either orally or written and any relevant information submitted with the complaint. The Division 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 Division Director or the Director's designee.
The Director or designee will meet with the parties and review any evidence presented. The Director or designee shall determine the best solution for the dispute. The Director or designee will prepare a concise written summary of the finding and decision and send it to the parties involved. Either party may request an independent review if they do not agree with the Director's decision. Based on interviews with the parties and a review of the evidence, the independent reviewer will prepare for the 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. There is no limit to the amount of elapsed time that has occurred when a complaint may be filed. This Representative is specifically assigned to 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 including support coordinators, complaints about the way in which providers deliver services, complaints about individual personnel within a provider agency, complaints about DSPD and its Administrative Program Managers and other personnel associated with the Operating Agency or decisions made or actions taken by those personnel, etc.

The Quality Assurance Team within the Bureau of Authorization and Community Based Services investigates complaints/grievances that are reported to the SMA and pertain to the operation of the CSW program. 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 or on the first business day after 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, abuse or 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, events that compromise participants' working or living environment such as damage to the work place or home that requires evacuation, and events that are anticipated to receive media, legislative, or other public scrutiny.

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 and submits the DSPD Form 1-8 to the support coordinator. If the person reporting is unable to complete the DSPD Form 1-8, accommodations are made and the support coordinator completes Form 1-8.

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

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. 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 an incident report with DSPD:
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 of 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 DHS/DSPD Statement of Interest and Qualifications #DHS40335 Section Two: Scope of Services, 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 complete a minimum of 12 hours of training each year. The Contractor operating licensed facilities shall train staff in behavior management each year per Utah Administrative Code, Rule, DHS, Office of Licensing (OL) (which may be referred to as DHS/OL) Rule R501-2-7.

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 completed Critical Incident/Event Investigation document 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. The SMA then completes the Critical Incident/Event Final SMA Report which includes a summary of the incident/event, remediation activities and SMA Findings and Recommendations. 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 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 preventive strategies are identified. The service plan is amended as dictated by the circumstances.

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 monitors the use of restrictive interventions during formal reviews and also when reviewing critical incident notifications. The SMA 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 formal 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 SMA has established a Critical Incident/Event Notification system that requires DSPD to notify the SMA of any serious incidents. The SMA reviews, on an ongoing basis, 100% of the use of restrictive interventions that are reported as part of critical incident notifications.

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 uses 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 100% of data at least annually. The reports generated from this review will be sent to the SMA for review.

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:

During annual reviews the SMA reviews all incident reports that relate to participants in the review sample and pertain to the use of restrictive interventions. The SMA also reviews participant records annually and every five years 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 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 Care, 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:
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.

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 competency3. 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 plans 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 DSPD's Quality Assurance Team as well as the DSPD's 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 that result in non-routine medical intervention are reported by providers to the Division of Services for People with Disabilities. Medication errors considered to be critical incidents are then reported by DSPD to the SMA.
	(b) Specify the types of medication errors that providers are required to *record:*
	Providers must record all medication errors including: wrong dose, wrong time, wrong route, and wrong medication or missed medication. Medication error logs will be made available for DSPD and/or SMA review upon request.
	(c) Specify the types of medication errors that providers must *report* to the State:
	Any medication errors that result in non-routine medical intervention will be reported on an incident report form and will be submitted to the support coordinator and the provider director or designee within 24 hours or on the first business day after the event. Medication overdoses or medication errors reasonably requiring medical intervention must be reported to DSPD by the provider within 24 hours or on the first business day after the event occurred. Medication errors that result in death, hospitalization or other serious outcomes must be reported by DSPD to the SMA within 24 hours or on the first business day after the event occurred.
○	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.

The SMA monitors the performance of waiver providers in the administration of medications to waiver participants during formal reviews and also when reviewing critical incident notifications. The SMA reviews participant records and conducts interviews with providers and participants to determine if participants are appropriately receiving their medications and all incidents of medication errors have been reported and addressed. Psychotropic Medication Plans are also reviewed to determine if the use of medications 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 any rights restrictions with medications. The formal 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. A response

distribution = 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

The SMA has established a Critical Incident/Event Notification system that requires DSPD to notify the SMA of any serious incidents. The SMA reviews, on an ongoing basis, 100% of the medication incidents/events that are reported as part of critical incident notifications.

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

The SMA receives and reviews the findings from the above monitoring activities.

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	**Number and percentage of referrals made to Adult Protective**

***Measure:* #1**	**Services, Child Protective Services and/or law enforcement according to State law.**		
Data Source ***DSPD Records*** ***Participant Records*** ***Incident Reports*** ***DSPD Annual Incident Report*** ***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*	
		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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. SMA: At a minimum of two times every five years.	

***Performance Measure:* #2**	**Number and percentage of incidents reported to the Support Coordinator within 24 hours 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*	
		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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. SMA: At a minimum of two times every five years.	

***Performance Measure:* #3**	**Number and percentage of incident reports completed on Form 1-8 and submitted to the support coordinator within 5 business days of the**

	occurrence.		
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*	**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*	
	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 of two times every five years.	

Performance Measure: #4	**Number and percentage of prevention strategies developed and implemented (when warranted) when an incident is identified.**		
Data Source ***Participant Records***	***Responsible Party for data collection/generation*** *(check each that*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

***Performance Measure:* #5**	**Number and percentage of participants who have assistance when needed to take their medications.**		
Data Source ***Critical Incident data***	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify: OA: At a minimum every two years. SMA: At a minimum of two times every five years.*	

Performance Measure: #6	**Number and percentage of back up plans that are effective and implemented when necessary.**		
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)*
	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*	
		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:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X *Other: Specify:* OA: At a minimum every two years. SMA: At a minimum of two times every five years.	

Performance Measure: #9	**Number and percentage of participants who have been informed of the complaint reporting process.**		
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*	**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***	***Frequency of data aggregation and analysis:***	

	(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 of every two years.* *SMA: at a minimum of two times every five years.*	

***Performance Measure:* #10**	**Number and percentage of participants who have been been informed of how to report abuse, neglect and exploitation.**		
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*	**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*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and*	

		Ongoing	
		X *Other: Specify:* *OA: at a minimum of every two years.* *SMA: at a minimum of two times 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, Child Protective Services and/or law enforcement according to State laws. Prevention strategies are developed and implemented (when warranted), when abuse, neglect, or exploitation are reported. Health and welfare needs are addressed and steps are taken to resolve concerns in a timely manner and are documented in the record. When an 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, 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 provides oversight of the investigations conducted by DSPD of all critical incidents/events. 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 director. If follow up is required, DSPD and the 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 recommendations are implemented. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5. A response distribution = 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

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 requiring immediate attention are addressed in a variety of ways. Depending on the circumstances of the individual case the interventions could include: contacting the OA, case management and/or direct care provider agencies requiring an immediate review and remediation of the issue, reporting the issue to

Utah Adult Protective Services, Utah Child Protective Services and/or local law enforcement or the state's Medicaid Fraud Control Unit, the licensing authority or the survey/certification authority. To assure the issue has been addressed, entities assigned the responsibility of review and remediation are required to report back to the OA or SMA on the results of their interventions within designated time frames. A description of issues requiring immediate attention and outcomes are documented through the SMA final report. Issues that are less immediate are corrected within designated time frames and are documented through the SMA final review report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained by the SMA. Findings and remediation will be documented in DSPD and SMA Annual Reports.

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 of two times 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: Systems Improvement

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

H.1 Systems Improvement

H.1.a.i Describe the process(es) for trending, prioritizing and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

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

H.1.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

H.1.b.i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes, and how the results of the changes and the assessment are communicated (and with what frequency) to stakeholders, including participants, families, providers, agencies and other interested parties. If applicable, include the State's targeted standards for systems improvement.

The SMA will establish a Quality Improvement Committee consisting of the SMA Quality Assurance Team, the 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 and the DSPD web site.

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

The Quality Improvement Strategy is a dynamic document that is continuously evaluated each year by the SMA's quality management team. The team evaluates the data collection process and makes changes as necessary to allow for accurate data collection and analysis. In addition the Quality Improvement Committee will evaluate the QIS after the third year of the waiver operation. This committee will meet to discuss the elements of the QIS for each assurance, the findings relative to each performance measure and the contributions of all parties that conduct quality assurance of the CSW. 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; and
4. 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. 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) agree to bill the MMIS directly or Voluntarily Reassign Payment to DHS/DSPD.
2. The State Medicaid Agency reimburses DSPD for any interim payments that are made for legitimate waiver service claims during the time the clean claim is being processed through the MMIS system.
3. The State Medicaid Agency receives from DSPD the State matching funds associated with the Waiver expenditures prior to the State Medicaid Agency's drawing down federal funds.
4. The State Medicaid Agency approves all proposed rules, policies, and other documents related to 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 made for services identified on a participant's service plan and which, in total, do not exceed the participant's annual budget.**		
Data Source • **Participant Claims Data**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

• **PCSP** • **Participant Budgets**			
	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*	
		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: #2	**Number and percentage of participant claims paid for services that use approved waiver codes and rates.**		
Data Source • **Participant Claims Data** • **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)*

• **Participant Budgets**			
	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*	
		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: #3	**Number and percentage of provider financial records 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*	
		X *Other: Specify:*	

Performance Measure: #4	**Number and percentage of provider claims submitted and processed through the CAPS which match the DSPD claims submitted and processed through the MMIS.**		
Data Source • **CAPS 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:*	

State:	
Effective Date	

			☐ *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: **#5**	**Number and percentage of recovered claims identified and processed correctly through MMIS with an audit trail of the claim paid in error and for which overpayments are returned to the federal government within required time frames.**		
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:*	**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 an annual review of the CSW program for each of the five waiver 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. A response distribution = 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

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.

• 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.

• 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 required time frames.

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).

CS Waiver Rates

The SMA has reviewed the CS waiver rates and the rate setting methodologies. Below is a list of the services and the rate information:

The following service is rebased annually:
CS Waiver Support Coordination

The following services were rebased in 2005 and have received COLA adjustments:
Behavior Consultation I
Behavior Consultation II
Behavior Consultation III
Chore Services
Companion Services - 15 minute
Companion Services - Daily (6 hrs +)
Financial Management Services
Massage Therapy
Personal Budget Assistance - 15 minute
Personal Budget Assistance - Daily (6 hrs +)
Personal Care
Respite Care - 15 minute
Respite Care - Daily (6 hrs +)
Respite Care - Room and Board Included - Daily (6 hrs +)
Professional Medication Monitoring

The following services were based on a 1997 cost study and have received COLA adjustments (the SMA understands that these rates need to be reviewed and is planning on reviewing each of them during the current waiver approval period):
Day Supports (Site/Non-site) - Daily (6 hr avg)
Day Supports (Site/Non-site) – Hourly
Extended Living Supports
Homemaker
Residential Habilitation - Facility Based - DCFS (6 hrs +)
Residential Habilitation - Facility Based (6 hrs +)
Residential Habilitation - Host Home - DCFS (6 hrs +)
Residential Habilitation - Host Home (6 hrs +)
Supported Employment - 15 minute
Supported Employment - Daily (flat rate for all occurrences within a 24 hr day)

Supported Living
Family Training Services

The following services are paid using the actual cost of the service:
Environmental Adaptations – Home
Environmental Adaptations – Vehicle
Living Start-Up Costs
Specialized Medical Equipment/Supplies/Assistive Technology - Purchase
Specialized Medical Equipment/Supplies/Assistive Technology- Monthly Fee

The following services are paid using a Competitive Contract written in 2005 with slight increase in an amendment in 2007:
Personal Emergency Response System - Installation
Personal Emergency Response System - Purchase
Personal Emergency Response System - Service Fee Monthly

The following services are paid using the Utah Transportation Authority rate:
Transportation - Bus Pass Purchase
Transportation - Daily

The following service is paid using the State of Utah Employee mileage reimbursement:
Transportation – Mileage

Rate Review Timeline
DSPD is a Division within the Department of Human Services, and the Department establishes provider rates. The Department has agreed to reviewing half of the waiver provider rates by the end of state Fiscal Year 2011 (ends June 30, 2011) and the other half by the end of state Fiscal Year 2012 (ends June 30, 2012). The Department will begin with the most frequently used rates.

By the end of Fiscal Year 2011 (ends June 30, 2011), the following rates will be reviewed:

Service Code	Kind	Service Title	HCPCS Code
PROVIDER BASED			
COM	Daily	Companion Services	S5136U6
DSG	Daily	Day Supports Group	T2020U6
HHS	Daily	Host Home Supports	S5140U6
MTP	Daily	Motor Transportation Payment	T2002U6
PA1	Daily	Personal Assistant - Self Administered - SAS	S5126U6HR
PBA	Daily	Personal Budget Assistance	H2014U6
PPS	Daily	Professional Parent Supports	S5145U6
RHS	Daily	Residential Habilitation Supports	T2016U6
RP1	Daily	Routine Respite - Family Managed - Self Administered Services	S5151U6
RP2	Daily	Provider Facility Based Routine Respite without Room and Board	S5151U6

RP3 Daily Exceptional Care Respite without Room and Board S5151U6
RP4 Daily Routine Respite with Room and Board Included H0045U6
RP5 Daily Exceptional Care Respite with Room and Board included H0045U6
RP6 Daily Routine Respite with Room and Board - Family Managed H0045U6HR
RP7 Daily Routine Respite - Family Managed Group S5151U6
RP8 Daily Routine Respite with Room and Board - Family Managed Group H0045U6
SED Daily Supported Employment in a Group T2018U6
UTP Daily Daily Transportation T2002U6
Service Code Kind Service Title HCPCS Code
SELF-ADMINISTERED SERVICES VIA FINANCIAL MANAGEMENT SERVICES (FMS)
CO1 Daily Companion Service - Self Administered - SAS S5136U6HR
PA1 Daily Personal Assistant - Self Administered - SAS S5126U4
PA1 Daily Personal Assistant - Self Administered - SAS S5126U6HR
RP1 Daily Routine Respite - Family Managed - Self Administered Services S5151U6
RP1 Daily Routine Respite - Family Managed - Self Administered Services S5151U5
CO1 Quarter Hour Companion Service - Self Administered - SAS S5135U6HR
HS1 Quarter Hour Homemaker Services - Self Administered SAS S5130U6HR
PA1 Quarter Hour Personal Assistant - Self Administered - SAS S5125U6HR
RP1 Quarter Hour Routine Respite - Family Managed - Self Administered Services S5150U6
RP7 Quarter Hour Routine Respite - Family Managed Group S5150U6
RP8 Quarter Hour Routine Respite with Room and Board - Family Managed

Group H0045U6
SL1 Quarter Hour Supported Living Hourly - Family managed SAS T2017U6HR
TF1 Quarter Hour Family Training and Preparation - Self-Administered S5110U6

By the end of Fiscal Year 2012 (ends June 30, 2012), the following rates will be reviewed:

Service Code Kind Service Title HCPCS Code
DTP Kind Daily Transportation Payment S0215U6
FMS Monthly Fiscal Management Service T2040U6
PER Monthly Personal Emergency Response System - Monthly Fee S5161U6
SCE Monthly Support Coordination External T2022U6
SME Monthly Specialized Medical Needs Monthly T2028U6
UTA Monthly Transportation Supports/Bus Pass T2004U6
EA1 Need Environmental Accessibility Adaptations Home S5165U6
EA2 Need Environmental Accessibility Adaptations - Vehicular T2039U6
PEI Need Personal Emergency Response System Installation S5160U6
SM1 Need Specialized Medical Needs $0.00 - $5000. T2029U6

STC	Need	Residential Start Up Costs	T2038U6
BC2	Quarter Hour	Behavior Consultation II	H0023U6
BC3	Quarter Hour	Behavior Consultation III	H2019U6
CHA	Quarter Hour	Chore Services	S5120U6
COM	Quarter Hour	Companion Services	S5135U6
DSI	Quarter Hour	Day Supports for an Individual	T2021U6TU
DSP	Quarter Hour	DAY SUPPORTS- PARTIAL DAY	T2021U6TU
ELS	Quarter Hour	Extended Living Supports	H2021U5HB
Service Code	Kind	Service Title	HCPCS Code
ELS	Quarter Hour	Extended Living Supports	H2021U6HB
HSQ	Quarter Hour	Homemaker Services	S5130U6
PAC	Quarter Hour	Personal Assistance Services	S5125U6
PBA	Quarter Hour	Personal Budget Assistance	H0038U6
PM1	Quarter Hour	Professional Medication Monitoring by a Licensed Practical Nurse	H0034U6
PM2	Quarter Hour	Professional Medication Monitoring by a Registered Nurse	H2010U6
RP2	Quarter Hour	Provider Facility Based Routine Respite without Room and Board	S5150U6
RP3	Quarter Hour	Exceptional Care Respite without Room and Board	S5150U6
SEC	Quarter Hour	Supported Employment with a Co-Worker	H2025U6
SEE	Quarter Hour	Supported Employment - Self employment	T2019U6
SEI	Quarter Hour	Supported Employment for an Individual	T2019U6
SLH	Quarter Hour	Supported Living Hourly	T2017U6
SLN	Quarter Hour	Supported Living with Natural Supports	T2017U6EY
TFB	Quarter Hour	Family and Individual Training and Preparation	T1027U6
BC1	Quarter Hour	Behavior Consultation Service I	H0004U6
RPS	Session	Respite Session	T2036U6
SSM	Session	Specialized Supports/Massage Therapy	T2025U6
STC	Session	Residential Start Up Costs	T2038U6
UTA	Bus Pass	Transportation Supports/Bus Pass	T2003U6

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

For Providers who Voluntarily Reassign Payment to DHS/DSPD:

Requests for payments from the contracted providers are submitted to 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 self-administered services, 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.

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

• If the services listed on the billing prior authorization form are consistent with the PCSP and budget, the Operating Agency will submit a notice of approval to the provider authorizing them to bill the MMIS.

• If the services listed on the billing prior authorization form are not consistent with the PCSP or budget, billing for services will not be authorized by the Operating Agency. The Operating Agency will submit the denial notice to the provider that will include an explanation of why the prior authorization was denied.

Once the Operating Agency has approved the billing prior authorization forms, the provider will then submit claims directly thought the States' MMIS.

The Community Supports waiver only pays for Non-Medical transportation and only when in accordance with the written plan of care. No waiver expenditures are paid for by DWS and they are not a waiver provider.

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

2. Post-payment reviews are conducted by the Medicaid agency; reviews of a sample of 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 CAPS. The review will verify that the rates paid to providers through the CAPS 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), Contract, Approval and Provider System (CAPS). (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 CAPS to the SMA. The claims are then entered into the MMIS for payment. The SMA makes payment to DHS through an Intergovernmental Transfer of Funds (IGT). Each claim is individually identifiable at the level of the participant, provider, HCPCS and units of service paid.
(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 in CAPS.
(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.

CAPS along with supporting documentation and claim information processed through MMIS provide audit support. Plans of care including specifications of amount, frequency and duration of prescribed services are documented in USTEPS by case managers and result in payment authorizations in CAPS. Payment authorizations result in the generation of provider billings. Provider claims are accompanied by eligibility codes that detail whether services qualify for FFP. Claims for services rendered under Medicaid eligibility are then ported to MMIS where recipient and provider eligibility are verified and claims that are determined to be eligible for FFP result in reimbursement to DHS/DSPD. Individual claim information is documented in MMIS.

Utah DOH/DSPD IGT Process
1. The Department of Health (DOH) estimates the state seed amount for the quarter.
2. The DOH sends the IGT request to the Department Human Services (DHS) for the estimated amount.
3. DHS processes the IGT request.
4. DHS approves the request.
5. DOH receives the funds before the start of the quarter.
6. At the end of the quarter, DOH determines the actual seed amount based on the paid claims.
7. The DOH sends the IGT request to the Department of Human Services (DHS) for the actual paid amount.
8. DHS approves the IGT request and DOH receives the funds.
9. DOH refunds the estimated amount to DHS via an IGT.

Utah DSPD/UTA IGT Process
UTA is initially paid out of CAPS. Quarterly IGT's will occur prior to the start of the quarter. UTA will not receive payment for any services in that quarter until the quarterly IGT has been made to DSPD. This guarantees that the provider will not recycle the Federal share of the payment.

○	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 UDHS Form 520 is a paper billing invoice form that is either generated by the CAPS billing system and sent to contracted providers for their review and approval, or else is generated directly by contracted providers. The reviewed and approved Form 520 is then submitted to Division fiscal personnel for additional review and approval and it is then submitted to USDDS by Division data entry personnel for payment. The DSPD has internal controls in place to assure providers paid through the CAPS system receive payment that is equal to the payment DSPD receives from DOH including a comparison of DOH's MMIS Reference File rates with DSPD's CAPS rates for the same service, as per the DOH rate sheet provided each year. A comparison of MMIS HCPCS code/rate information with corresponding CAPS service code/rate information is implemented and documented via screen prints on a copy of a rate chart spreadsheet. This is completed before the beginning of each fiscal year when rates are generally adjusted, but a periodic review of CAPS to MMIS rates is completed throughout the year. Post rate adjustment billing detail is reviewed closely to ensure the agreed rates are correct on the claims submitted for reimbursement, as is the claims reimbursement detail. The SMA will perform an annual post payment review of claims that are paid to providers through the CAPS. The review will verify that the rates paid to providers through the CAPS are equal to the rates paid to DSPD through the MMIS. The rates schedules are coordinated between DOH and DSPD and the individual systems. In the event of a retro effective date, DOH and DSPD would coordinate the rate change in their system and DHS resubmit the previously paid claims through the MMIS system to be reprocessed. In the event of a retro effective rate change the following would occur: 1. The rates schedules would be coordinated between DOH and DSPD. 2. Providers would be notified of the rate change. 3. DSPD would have the rate set to the correct amount in CAPS and the claims would be reprocessed reflecting the new rate. 4. Providers payments would reflect the new rate. 5. The MMIS system would have the rate set at the correct amount and the affected claims would be reprocessed. 6. DSPD would receive their IGT that reflects the new rate.
☐	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.*

	STATE LEVEL SOURCE(S) OF THE NON-FEDERAL SHARE OF COMPUTABLE WAIVER COSTS a. The Department of Human Service is the source of the non-federal share that is appropriated to a state agency. The underlying source of the non-federal share is state general funds. b. The mechanism that is used to transfer the funds to the Medicaid Agency is an Intergovernmental Transfer (IGT). The IGT is made to the Medicaid Agency prior to any federal funds being drawn. LOCAL GOVERNMENT OR OTHER SOURCE(S) OF THE NON-FEDERAL SHARE OF COMPUTABLE WAIVER COSTS a. The Utah Transit Authority ("UTA"), a Utah public transit district, is the local governmental source of the non-federal share of computable waiver costs. b. The source of the funding from UTA is local sales and use taxes. The funds are publicly approved sales tax revenues levied by the cities and counties within UTA's service district. The taxes are collected quarterly from businesses from the sale of retail goods. The sales tax revenues are given to the transit authority for the operation of a local public transportation agency. c. The mechanism that is used to transfer funds from the UTA to the Department of Human Services is an IGT. After receiving funds from the UTA, the Department of Human Services will transfer the funds to the Medicaid Agency through an IGT. The reason the funds are transferred to the Department of Human Services rather than to the Medicaid Agency directly is that, in the event UTA chooses to discontinue providing the non-federal share of computable waiver costs, the Department of Human Services would become responsible to provide the non-federal share. The IGT is made to the Medicaid Agency prior to any federal funds being drawn.
○	**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) which 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 each quarter, the State Medicaid Agency will perform a reconciliation of the actual state match obligation and the prepaid amount. State Tax Revenues (general funds) are appropriated directly to the Department of Human Services by the legislature. The Division of Services for People with Disabilities (DSPD) which 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 each quarter, the State Medicaid Agency will perform a reconciliation of the actual state match obligation and the prepaid amount.
☐	**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:

X	**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:
	The source of the funding from UTA is local sales and use taxes. The funds are publicly approved sales tax revenues levied by the cities and counties within UTA's service district. The taxes are collected quarterly from businesses from the sale of retail goods. The sales tax revenues are given to the transit authority for the operation of a local public transportation agency.
	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)*:			ICF/ID				
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	$36,581	$6,403	$42,984	$75,363	$4,852	$80,215	$37,231
2	$36,170	$6,531	$42,701	$76,870	$4,949	$81,819	$39,118
3	$36,892	$6,662	$43,554	$78,408	$5,048	$83,456	$39,902
4	$37,633	$6,795	$44,428	$79,976	$5,149	$85,125	$40,697
5	$38,386	$6,931	$45,317	$81,575	$5,252	$86,827	$41,510

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	4666		
Year 2	4666		
Year 3	4666		
Year 4 (renewal only)	4666		
Year 5 (renewal only)	4666		

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) = 353 days
- Used the average annual LOS count for fiscal year 2009 (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:

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

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

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

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

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

Factor G is an estimate that is based off the actual preliminary utilization numbers for State fiscal year 2009. Factor G is calculated utilizing the average annual institutional costs of services for a person receiving ICF/ID level of care. These are the same services that would be furnished to waiver participants in the absence of the Community Supports Waiver. The average annual costs are then divided by the ICF/ID ALOS to calculate the average cost per day. The average cost per day is then multiplied by the Community Supports Waiver ALOS to get Factor G. To project the actual 2009 data forward to 2011 the following equation was used: (actual 2009 G) * ((1.02)^2). Also, a cost of living adjustment of two percent has been added to each additional year to address inflation and is within the medical consumer price index.

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

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

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

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	901	139	$5.53	$692,572
Behavior Consultation Services II	15 minute	748	116	$9.44	$819,090
Behavior Consultation Services III	15 minute	213	60	$14.46	$184,799
Chore Services	15 minute	90	567	$3.04	$155,131
Companion Services - 15 Minute	15 minute	76	1215	$2.91	$268,709
Companion Services - Daily	Daily	22	56	$69.24	$85,304
Day Supports (Site/Non-Site) - 15 Minute	15 minute	106	2277	$5.93	$1,431,277
Day Supports (Site/Non-Site) - Daily	Daily	1983	194	$57.63	$22,170,376
Environmental Adaptations (Home)	Each	72	2	$1,333.00	$191,952
Environmental Adaptations (Vehicle)	Each	7	1	$1,947.46	$13,632
Extended Living Supports	15 minute	345	1226	$3.96	$1,674,961
Family And Individual Training & Preparation	15 minute	9	25	$2.89	$650
Family Training And Preparation	15 minute	2	339	$5.53	$3,749
Financial Management Services	Monthly	1516	12	$39.00	$709,488
Homemaker Services	15 minute	45	957	$3.05	$131,348
Living Start-Up Costs	Each	6	1	$915.85	$5,495
Massage Therapy	15 minute	101	41	$42.52	$176,075
Personal Assistance - 15 Minute	15 minute	303	1411	$2.61	$1,115,861
Personal Assistance - Daily	Daily	57	45	$84.69	$217,230
Personal Budget Assistance - 15 Minute	15 minute	198	78	$5.77	$89,112
Personal Budget Assistance - Daily	Daily	1436	23	$11.65	$384,776
Personal Emergency Response Systems - Monthly	Monthly	50	11	$31.85	$17,518
Personal Emergency Response Systems - Purchase	Per episode	3	1	$149.58	$449
Personal Emergency Response Systems -Installation	Per episode	7	1	$51.00	$357
Professional Medication Monitoring, LPN	Per episode	331	178	$5.25	$309,320

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**
Professional Medication Monitoring, RN	Per episode	748	86	$7.66	$492,752
Residential Habilitation - Facility Based	Daily	1490	328	$162.61	$79,470,759
Residential Habilitation-facility based-DCFS	Daily	120	315	$140.39	$5,306,742
Residential Habilitation - Host Home	Daily	151	300	$114.74	$5,197,722
Residential Habilitation - Professional Parent -DCFS	Daily	157	312	$128.39	$6,289,056
Respite Care - 15 Minute	15 minute	984	1136	$2.39	$2,671,599
Respite Care - Daily	Daily	673	34	$59.16	$1,353,699
Respite Care - Group - Daily	Daily	132	24	$41.05	$130,046
Respite Care - Intensive - Daily	Daily	75	19	$85.41	$121,709
Respite Care - Intensive - Out Of Home/R&B Inc.	Daily	21	24	$95.94	$48,354
Respite Care - Intensive -15 Minute	15 minute	146	561	$3.77	$308,786
Respite Care - Out Of Home/Group/R&B Inc.	Daily	14	70	$35.95	$35,231
Respite Care - Out Of Home/R&B Inc.	Daily	130	27	$70.86	$248,719
Respite Care, Weekly	Per episode	512	31	$145.71	$2,312,709
Specialized Medical Equipment, Monthly	Monthly	2	1	$469.20	$938
Specialized Medical Equipment, Purchase	Each	120	2	$771.92	$185,261
Supported Employment - 15 Minute	15 minute	554	1106	$7.47	$4,577,048
Supported Employment - Daily	Daily	297	196	$35.45	$2,063,615
Supported Living	15 minute	1471	1875	$4.59	$12,659,794
Transportation, Non-Medical - Bus Pass Purchase	Per episode	384	9	$83.19	$287,505
Transportation, Non-Medical - Daily	Daily	1512	276	$8.67	$3,618,095
Transportation, Non-Medical - Daily (Utah Transit Authority Provided)	Daily	387	276	$10.54	$1,125,798
Transportation, Non-Medical - Per Mileage	Per mile	69	2207	$0.35	$53,299
Transportation - one way	Per episode	128	260	$4.18	$139,110
Waiver Support Coordination	Monthly	4666	12	$198.98	$11,141,288
GRAND TOTAL:					$170,688,865
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4666

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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
FACTOR D (Divide total by number of participants)					$36,581
AVERAGE LENGTH OF STAY ON THE WAIVER					353

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	850	145	$5.64	$695,130
Behavior Consultation Services II	15 minute	760	130	$9.63	$951,444
Behavior Consultation Services III	15 minute	250	77	$14.75	$283,938
Chore Services	15 minute	90	567	$3.10	$158,193
Companion Services - 15 Minute	15 minute	76	1320	$2.97	$297,950
Companion Services - Daily	Daily	20	112	$70.62	$158,189
Day Supports (Site/Non-Site) - 15 Minute	15 minute	140	1890	$6.05	$1,600,830
Day Supports (Site/Non-Site) - Daily	Daily	1983	194	$58.78	$22,612,784
Environmental Adaptations (Home)	Each	45	2	$1,359.66	$122,369
Environmental Adaptations (Vehicle)	Each	6	1	$1,986.41	$11,918
Extended Living Supports	15 minute	345	1226	$4.04	$1,708,799
Family And Individual Training & Preparation	15 minute	4	400	$2.95	$4,720
Family Training And Preparation	15 minute	2	12	$5.64	$135
Financial Management Services	Monthly	1516	12	$39.78	$723,678
Homemaker Services	15 minute	45	957	$3.11	$133,932
Living Start-Up Costs	Each	6	1	$934.17	$5,605
Massage Therapy	15 minute	110	41	$14.08	$63,501
Personal Assistance - 15 Minute	15 minute	290	1411	$2.66	$1,088,445
Personal Assistance - Daily	Daily	61	48	$86.38	$252,921
Personal Budget Assistance - 15 Minute	15 minute	200	78	$5.89	$91,884

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Personal Budget Assistance - Daily	Daily	1436	23	$11.88	$392,373
Personal Emergency Response Systems - Monthly	Monthly	50	11	$32.49	$17,870
Personal Emergency Response Systems - Purchase	Per episode	3	1	$152.57	$458
Personal Emergency Response Systems -Installation	Per episode	7	1	$52.02	$364
Professional Medication Monitoring, LPN	Per episode	300	181	$5.36	$291,048
Professional Medication Monitoring, RN	Per episode	748	86	$7.81	$502,402
Residential Habilitation - Facility Based	Daily	1400	335	$165.86	$77,788,340
Residential Habilitation-facility based-DCFS	Daily	85	300	$143.20	$3,651,600
Residential Habilitation - Host Home	Daily	151	315	$117.03	$5,566,532
Residential Habilitation - Professional Parent -DCFS	Daily	150	325	$130.96	$6,384,300
Respite Care - 15 Minute	15 minute	900	1236	$2.44	$2,714,256
Respite Care - Daily	Daily	605	34	$60.34	$1,241,194
Respite Care - Group - Daily	Daily	132	36	$41.87	$198,966
Respite Care - Intensive - Daily	Daily	51	25	$87.12	$111,078
Respite Care - Intensive - Out Of Home/R&B Inc.	Daily	21	15	$97.86	$30,826
Respite Care - Intensive -15 Minute	15 minute	132	660	$3.85	$335,412
Respite Care - Out Of Home/Group/R&B Inc.	Daily	10	131	$36.67	$48,038
Respite Care - Out Of Home/R&B Inc.	Daily	125	30	$72.28	$271,050
Respite Care, Weekly	Per episode	465	33	$148.62	$2,280,574
Specialized Medical Equipment, Monthly	Monthly	2	1	$478.58	$957
Specialized Medical Equipment, Purchase	Each	70	2	$787.36	$110,230
Supported Employment - 15 Minute	15 minute	490	1090	$7.62	$4,069,842
Supported Employment - Daily	Daily	297	196	$36.16	$2,104,946
Supported Living	15 minute	1471	1959	$4.68	$13,486,305
Transportation, Non-Medical - Bus Pass Purchase	Per episode	390	6	$84.85	$198,549
Transportation, Non-Medical - Daily	Daily	2050	180	$8.84	$3,261,960
Transportation, Non-Medical - Daily	Daily	387	276	$11.26	$1,202,703

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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
(Utah Transit Authority Provided)					
Transportation, Non-Medical - Per Mileage	Per mile	85	1620	$0.37	$50,949
Transportation - one way	Per episode	205	140	$4.44	$127,428
Waiver Support Coordination	Monthly	4666	12	$202.96	$11,364,136
GRAND TOTAL:					$168,771,051
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4,666
FACTOR D (Divide total by number of participants)					$36,170
AVERAGE LENGTH OF STAY ON THE WAIVER					353

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	850	145	$5.75	$708,688
Behavior Consultation Services II	15 minute	760	130	$9.82	$970,216
Behavior Consultation Services III	15 minute	250	77	$15.05	$289,713
Chore Services	15 minute	90	567	$3.16	$161,255
Companion Services - 15 Minute	15 minute	76	1320	$3.03	$303,970
Companion Services - Daily	Daily	20	112	$72.03	$161,347
Day Supports (Site/Non-Site) - 15 Minute	15 minute	140	1890	$6.17	$1,632,582
Day Supports (Site/Non-Site) - Daily	Daily	1983	194	$59.96	$23,066,732
Environmental Adaptations (Home)	Each	45	2	$1,386.85	$124,817
Environmental Adaptations (Vehicle)	Each	6	1	$2,026.14	$12,157
Extended Living Supports	15 minute	345	1226	$4.12	$1,742,636
Family And Individual Training & Preparation	15 minute	4	400	$3.01	$4,816
Family Training And Preparation	15 minute	2	12	$5.75	$138
Financial Management Services	Monthly	1516	12	$40.58	$738,231
Homemaker Services	15 minute	45	957	$3.17	$136,516
Living Start-Up Costs	Each	6	1	$952.85	$5,717
Massage Therapy	15 minute	110	41	$14.36	$64,764
Personal Assistance - 15 Minute	15 minute	290	1411	$2.71	$1,108,905
Personal Assistance - Daily	Daily	61	48	$88.11	$257,986

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Personal Budget Assistance - 15 Minute	15 minute	200	78	$6.01	$93,756
Personal Budget Assistance - Daily	Daily	1436	23	$12.12	$400,299
Personal Emergency Response Systems - Monthly	Monthly	50	11	$33.14	$18,227
Personal Emergency Response Systems - Purchase	Per episode	3	1	$155.62	$467
Personal Emergency Response Systems -Installation	Per episode	7	1	$53.06	$371
Professional Medication Monitoring, LPN	Per episode	300	181	$5.47	$297,021
Professional Medication Monitoring, RN	Per episode	748	86	$7.97	$512,694
Residential Habilitation - Facility Based	Daily	1400	335	$169.18	$79,345,420
Residential Habilitation-facility based-DCFS	Daily	85	300	$146.06	$3,724,530
Residential Habilitation - Host Home	Daily	151	315	$119.37	$5,677,834
Residential Habilitation - Professional Parent -DCFS	Daily	150	325	$133.58	$6,512,025
Respite Care - 15 Minute	15 minute	900	1236	$2.49	$2,769,876
Respite Care - Daily	Daily	605	34	$61.55	$1,266,084
Respite Care - Group - Daily	Daily	132	36	$42.71	$202,958
Respite Care - Intensive - Daily	Daily	51	25	$88.86	$113,297
Respite Care - Intensive - Out Of Home/R&B Inc.	Daily	21	15	$99.82	$31,443
Respite Care - Intensive -15 Minute	15 minute	132	660	$3.93	$342,382
Respite Care - Out Of Home/Group/R&B Inc.	Daily	10	131	$37.40	$48,994
Respite Care - Out Of Home/R&B Inc.	Daily	125	30	$73.73	$276,488
Respite Care, Weekly	Per episode	465	33	$151.59	$2,326,149
Specialized Medical Equipment, Monthly	Monthly	2	1	$488.15	$976
Specialized Medical Equipment, Purchase	Each	70	2	$803.11	$112,435
Supported Employment - 15 Minute	15 minute	490	1090	$7.77	$4,149,957
Supported Employment - Daily	Daily	297	196	$36.88	$2,146,859
Supported Living	15 minute	1471	1959	$4.77	$13,745,657
Transportation, Non-Medical - Bus Pass Purchase	Per episode	390	6	$86.55	$202,527

State:	
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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
Transportation, Non-Medical - Daily	Daily	2050	180	$9.02	$3,328,380
Transportation, Non-Medical - Daily (Utah Transit Authority Provided)	Daily	387	276	$11.49	$1,227,270
Transportation, Non-Medical - Per Mileage	Per mile	85	1620	$0.38	$52,326
Transportation - one way	Per episode	205	140	$4.53	$130,011
Waiver Support Coordination	Monthly	4666	12	$207.02	$11,591,464
GRAND TOTAL:					$172,139,363
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4666
FACTOR D (Divide total by number of participants)					$36,892
AVERAGE LENGTH OF STAY ON THE WAIVER					353

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	850	145	$5.87	$723,478
Behavior Consultation Services II	15 minute	760	130	$10.02	$989,976
Behavior Consultation Services III	15 minute	250	77	$15.35	$295,488
Chore Services	15 minute	90	567	$3.22	$164,317
Companion Services - 15 Minute	15 minute	76	1320	$3.09	$309,989
Companion Services - Daily	Daily	20	112	$73.47	$164,573
Day Supports (Site/Non-Site) - 15 Minute	15 minute	140	1890	$6.29	$1,664,334
Day Supports (Site/Non-Site) - Daily	Daily	1983	194	$61.16	$23,528,374
Environmental Adaptations (Home)	Each	45	2	$1,414.59	$127,313
Environmental Adaptations (Vehicle)	Each	6	1	$2,066.66	$12,400
Extended Living Supports	15 minute	345	1226	$4.20	$1,776,474
Family And Individual Training & Preparation	15 minute	4	400	$3.07	$4,912
Family Training And Preparation	15 minute	2	12	$5.87	$141
Financial Management Services	Monthly	1516	12	$41.39	$752,967
Homemaker Services	15 minute	45	957	$3.23	$139,100
Living Start-Up Costs	Each	6	1	$971.91	$5,831
Massage Therapy	15 minute	110	41	$14.65	$66,072

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
Personal Assistance - 15 Minute	15 minute	290	1411	$2.76	$1,129,364
Personal Assistance - Daily	Daily	61	48	$89.87	$263,139
Personal Budget Assistance - 15 Minute	15 minute	200	78	$6.13	$95,628
Personal Budget Assistance - Daily	Daily	1436	23	$12.36	$408,226
Personal Emergency Response Systems - Monthly	Monthly	50	11	$33.80	$18,590
Personal Emergency Response Systems - Purchase	Per episode	3	1	$158.73	$476
Personal Emergency Response Systems -Installation	Per episode	7	1	$54.12	$379
Professional Medication Monitoring, LPN	Per episode	300	181	$5.58	$302,994
Professional Medication Monitoring, RN	Per episode	748	86	$8.13	$522,987
Residential Habilitation - Facility Based	Daily	1400	335	$172.56	$80,930,640
Residential Habilitation-facility based-DCFS	Daily	85	300	$148.98	$3,798,990
Residential Habilitation - Host Home	Daily	151	315	$121.76	$5,791,514
Residential Habilitation - Professional Parent -DCFS	Daily	150	325	$136.25	$6,642,188
Respite Care - 15 Minute	15 minute	900	1236	$2.54	$2,825,496
Respite Care - Daily	Daily	605	34	$62.78	$1,291,385
Respite Care - Group - Daily	Daily	132	36	$43.56	$206,997
Respite Care - Intensive - Daily	Daily	51	25	$90.64	$115,566
Respite Care - Intensive - Out Of Home/R&B Inc.	Daily	21	15	$101.82	$32,073
Respite Care - Intensive -15 Minute	15 minute	132	660	$4.01	$349,351
Respite Care - Out Of Home/Group/R&B Inc.	Daily	10	131	$38.15	$49,977
Respite Care - Out Of Home/R&B Inc.	Daily	125	30	$75.20	$282,000
Respite Care, Weekly	Per episode	465	33	$154.62	$2,372,644
Specialized Medical Equipment, Monthly	Monthly	2	1	$497.91	$996
Specialized Medical Equipment, Purchase	Each	70	2	$819.17	$114,684
Supported Employment - 15 Minute	15 minute	490	1090	$7.93	$4,235,413
Supported Employment - Daily	Daily	297	196	$37.62	$2,189,935

State:	
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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	1471	1959	$4.87	$14,033,825
Transportation, Non-Medical - Bus Pass Purchase	Per episode	390	6	$88.28	$206,575
Transportation, Non-Medical - Daily	Daily	2050	180	$9.20	$3,394,800
Transportation, Non-Medical - Daily (Utah Transit Authority Provided)	Daily	387	276	$11.72	$1,251,837
Transportation, Non-Medical - Per Mileage	Per mile	85	1620	$0.39	$53,703
Transportation - one way	Per episode	205	140	$4.62	$132,594
Waiver Support Coordination	Monthly	4666	12	$211.16	$11,823,271
GRAND TOTAL:					$175,593,976
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4666
FACTOR D (Divide total by number of participants)					$37,633
AVERAGE LENGTH OF STAY ON THE WAIVER					353

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	850	145	$5.99	$738,268
Behavior Consultation Services II	15 minute	760	130	$10.22	$1,009,736
Behavior Consultation Services III	15 minute	250	77	$15.66	$301,455
Chore Services	15 minute	90	567	$3.28	$167,378
Companion Services - 15 Minute	15 minute	76	1320	$3.15	$316,008
Companion Services - Daily	Daily	20	112	$74.94	$167,866
Day Supports (Site/Non-Site) - 15 Minute	15 minute	140	1890	$6.42	$1,698,732
Day Supports (Site/Non-Site) - Daily	Daily	1983	194	$62.38	$23,997,711
Environmental Adaptations (Home)	Each	45	2	$1,442.88	$129,859
Environmental Adaptations (Vehicle)	Each	6	1	$2,107.99	$12,648
Extended Living Supports	15 minute	345	1226	$4.28	$1,810,312
Family And Individual Training & Preparation	15 minute	4	400	$3.13	$5,008
Family Training And Preparation	15 minute	2	12	$5.99	$144
Financial Management Services	Monthly	1516	12	$42.22	$768,066
Homemaker Services	15 minute	45	957	$3.29	$141,684

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
Living Start-Up Costs	Each	6	1	$991.35	$5,948
Massage Therapy	15 minute	110	41	$14.94	$67,379
Personal Assistance - 15 Minute	15 minute	290	1411	$2.82	$1,153,916
Personal Assistance - Daily	Daily	61	48	$91.67	$268,410
Personal Budget Assistance - 15 Minute	15 minute	200	78	$6.25	$97,500
Personal Budget Assistance - Daily	Daily	1436	23	$12.61	$416,483
Personal Emergency Response Systems - Monthly	Monthly	50	11	$34.48	$18,964
Personal Emergency Response Systems - Purchase	Per episode	3	1	$161.90	$486
Personal Emergency Response Systems -Installation	Per episode	7	1	$55.20	$386
Professional Medication Monitoring, LPN	Per episode	300	181	$5.69	$308,967
Professional Medication Monitoring, RN	Per episode	748	86	$8.29	$533,279
Residential Habilitation - Facility Based	Daily	1400	335	$176.01	$82,548,690
Residential Habilitation-facility based-DCFS	Daily	85	300	$151.96	$3,874,980
Residential Habilitation - Host Home	Daily	151	315	$124.20	$5,907,573
Residential Habilitation - Professional Parent -DCFS	Daily	150	325	$138.98	$6,775,275
Respite Care - 15 Minute	15 minute	900	1236	$2.59	$2,881,116
Respite Care - Daily	Daily	605	34	$64.04	$1,317,303
Respite Care - Group - Daily	Daily	132	36	$44.43	$211,131
Respite Care - Intensive - Daily	Daily	51	25	$92.45	$117,874
Respite Care - Intensive - Out Of Home/R&B Inc.	Daily	21	15	$103.86	$32,716
Respite Care - Intensive -15 Minute	15 minute	132	660	$4.09	$356,321
Respite Care - Out Of Home/Group/R&B Inc.	Daily	10	131	$38.91	$50,972
Respite Care - Out Of Home/R&B Inc.	Daily	125	30	$76.70	$287,625
Respite Care, Weekly	Per episode	465	33	$157.71	$2,420,060
Specialized Medical Equipment, Monthly	Monthly	2	1	$507.87	$1,016
Specialized Medical Equipment,	Each	70	2	$835.55	$116,977

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**
Purchase					
Supported Employment - 15 Minute	15 minute	490	1090	$8.09	$4,320,869
Supported Employment - Daily	Daily	297	196	$38.37	$2,233,594
Supported Living	15 minute	1471	1959	$4.97	$14,321,994
Transportation, Non-Medical - Bus Pass Purchase	Per episode	390	6	$90.05	$210,717
Transportation, Non-Medical - Daily	Daily	2050	180	$9.38	$3,461,220
Transportation, Non-Medical - Daily (Utah Transit Authority Provided)	Daily	387	276	$11.95	$1,276,403
Transportation, Non-Medical - Per Mileage	Per mile	85	1620	$0.40	$55,080
Transportation - one way	Per episode	205	140	$4.71	$135,177
Waiver Support Coordination	Monthly	4666	12	$215.38	$12,059,557
GRAND TOTAL:					$179,110,833
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4666
FACTOR D (Divide total by number of participants)					$38,386
AVERAGE LENGTH OF STAY ON THE WAIVER					353

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						