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:	March 31, 2011

CMS Receipt Date *(CMS Use)*	

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

1. Major Changes:

The state is proposing very few changes to the Physical Disabilities waiver. No new services are being recommended as waiver participant surveys have demonstrated satisfaction with all waiver services currently offered. The only major changes suggested include the following:

- Payment to Parents or Step-parents for Personal Attendant Deemed Extraordinary
  - Parents or step-parents may be paid to provide personal attendant services to their adult child under the following circumstances:
    - the participant lives in a rural area and has conducted active recruitment of resources other than the parent,
    - the caregiver has specialized training that no other qualified resource is available to provide,
    - the participant is functionally quadriplegic and dependent on others to perform health and safety related supports, or
    - the participant needs supports critical to health and safety during non-traditional work hours.
- Increased Visits between Participants and Administrative Case Managers
  - Administrative case managers will now be required to have face-to-face visits at least once every six months and additional contacts will take

place by phone on at least a quarterly basis.

- Quality Improvement
    - 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 System Improvements.

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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

State:	
Effective Date	

1. Request Information

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

B. Waiver Title (*optional*): **Physical Disabilities Waiver**

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

O	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
O	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
X	**Renewal (5 Years) of Waiver #**	**0331.90.R3**	
O	**Amendment to Waiver #**		

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

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

E.1 Proposed Effective Date: **July 1, 2011**

E.2 Approved Effective Date *(CMS Use)*:

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

☐	Hospital *(select applicable level of care)*	
	O	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	O	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
X	Nursing Facility *(select applicable level of care)*	
	X	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	O	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

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

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

H. Dual Eligibility for Medicaid and Medicare. *(Check if applicable)*:

X	This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

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.

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

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 (DSPD), in conjunction with the helpful contribution of Physical Disabilities waiver participants through DSPD administered surveys and interviews geared to identify the needs of all (100%) of the PD waiver population, completed the initial draft application September 29, 2010. The agencies convened a work group consisting of consumers, advocates, providers, Independent Living Centers' representatives and state agency representatives to review the initial draft application. Two workgroup meetings were completed during October 2010. Amendments to the draft were completed November 2010. The revised draft

was submitted to a broad network of consumers, advocates, providers and Tribal Governments, as well as the Medical Care Advisory Committee (MCAC), in January 2011. The entities had 30 days in which to submit comments or questions about the Physical Disabilities Waiver Application.

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

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

7. Contact Person(s)

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

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

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

First Name:	Alan
Last Name	Ormsby
Title:	Division Director
Agency:	Department of Human Services, Division of Services for People with Disabilities
Address 1:	195 North 1950 West
Address 2	

City	Salt Lake City
State	Utah
Zip Code	84116
Telephone:	801-538-4135
E-mail	akormsby@utah.gov
Fax Number	801-538-4279

8. Authorizing Signature

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

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

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Michael
Last Name	Hales
Title:	Deputy Director
Agency:	Department of Health, Division of Medicaid and Health Financing
Address 1:	288 N. 1460 W.
Address 2:	PO Box 143101
City	Salt Lake City
State	Utah
Zip Code	84114-3101
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:

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 (DSPD)**	
	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 a five year period, 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. All of these responsibilities are shared to some extent with the SMA:

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

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

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

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

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

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
X	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

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

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

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

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

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

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

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

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

***Performance Measure:* #1**	**Number and percentage of OA annual reports specified in the implementation plan that were submitted to the SMA on time and in the correct format.**		
Data Source • **DSPD Annual reports** • **DSPD Annual Incident report**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *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:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure: #2	**Number and percentage of participants who received an annual level of care redetermination conducted at a minimum within 12 consecutive months of the last recorded level of care evaluation.**		
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*	☐ *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*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	

		☐ *Other: Specify:*	

Performance Measure: #3	**Number and percentage of OA 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	**Number and percentage of maximum allowable rates (MARs) for covered waiver services approved by the SMA.**		
Data Source	***Responsible Party for***	***Frequency of data***	***Sampling Approach***

• **Rate setting meetings minutes** • **Approval documentation** • **Correspondence**	***data collection/generation*** *(check each that applies)*	***collection/generation:*** *(check each that applies)*	*(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 the OA notifies the SMA on the first business day after occurrence as per SMA protocol.**		
Data Source • **Critical Incident/ Event findings**	***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:*	

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 PD waiver program through numerous activities including the issuance of policies, rules, and regulations relating to the waiver, the approval of all protocols, documents and trainings that affect any aspect of the PD waiver operations. Approvals are accomplished through a formal document approval process. The SMA also conducts quarterly meetings with DSPD (the operating agency), monitors compliance with the Interagency Agreement, conducts annual quality assurance reviews of the PD waiver 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 verifies compliance with the Administrative Authority performance measures annually. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to five. A response distribution equal to 50% will be used to gather base line data for the first waiver year. 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 PD waiver.

b. Methods for Remediation/Fixing Individual Problems

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

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 require corrective action to achieve 100% compliance. Remediation 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
X	**Aged or Disabled, or Both** *(select one)*				
	X	**Aged or Disabled or Both – General** *(check each that applies)*			
	X	Aged (age 65 and older)			X
	X	Disabled (Physical) (under age 65)	18		
	☐	Disabled (Other) (under age 65)			
	☐	**Specific Recognized Subgroups** *(check each that applies)*			
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
O	**Mental Retardation or Developmental Disability, or Both** *(check each that applies)*				
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
O	**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:

The individual must:

1) Have established programmatic eligibility through the Utah Department of Human Services for state matching funds in accordance with Title 62A-Chapter 5-Part 1 and UAC R539-1-6 by meeting the following criteria:
   a) Have at least one personal attendant trained (or willing to be trained) and available to provide the authorized waiver services in a residence that is safe and can accommodate the personnel and equipment (if any) needed to adequately and safely care for the individual. The operating agency will provide information to the individual about potential community resources to assist them in recruiting an attendant.
   b) Be medically stable, have a physical disability and require in accordance with his/her

physician's written documentation, at least 14 hours per week of personal assistance services (as described in appendix B of this waiver) in order to remain in the community and prevent unwanted institutionalization. For purposes of this waiver, the individual's qualifying disability and need for personal assistance services are attested to by a medically determinable physical impairment which the physician will expect to last for a continuous period of not less than 12 months and which has resulted in the individual's functional loss of two or more limbs, to the extent that the assistance of another trained person(s) is required in order to accomplish activities of daily living/instrumental activities of daily living.

c) Have decision making capability, as certified by his/her physician, of selecting, training and supervising her/his own attendant(s).*

d) Have decision making capability of managing the individual's own financial and legal affairs.

2) 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.

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

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

X	Not applicable – There is no maximum age limit
O	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	150
Year 2	150
Year 3	150
Year 4 (renewal only)	150
Year 5 (renewal only)	150

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.
O	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

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

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

X	The waiver is not subject to a phase-in or a phase-out schedule.
O	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

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

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

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

A. Medicaid recipients who meet the programmatic eligibility requirements as defined in Appendix B-1: 1b for the Physical Disabilities waiver may choose to receive services in a NF

(Nursing Facility) or through the Physical Disabilities waiver. If available capacity exists individuals are given the opportunity to choose to receive services to meet the identified needs through a NF or enter the Physical Disabilities waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the individual record.

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

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

The Division of Services for People with Disabilities has established a Critical Needs Assessment process by which individuals are ranked to prioritize access to waiver services. A significant component of the Critical Needs Assessment tool addresses the immediacy of the need for services and the individual's risk in not gaining access to waiver services.

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

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

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

C. The individual tracks do not take priority over each other as each track has its own funding process. Once a person in institutional care (nursing facility) is ready to transition from the nursing facility and is found eligible to receive services through the Physical Disabilities Waiver, as long as the number of unduplicated recipients authorized in the waiver has not been exceeded, the person may begin receiving services. The funding for individuals moving from nursing facilities into the Physical Disabilities Waiver is provided by the Department of Health, Division of Medicaid and Health Financing. Essentially the funding that the Medicaid agency was already paying for the individual's care while in the nursing facility is

allowed to “follow” the person into the waiver.

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

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)			
☐	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
☐	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)		
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special*			

home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed				
○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.			
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*):	
	○	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.*
	X	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*):				
X	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	X	The special income level for institutionalized persons *(select one):*		
		X	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	

O	The following dollar amount:	$	If this amount changes, this item will be revised.
O	The following formula is used to determine the needs allowance:		
O	Other (specify):		

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

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

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

O	AFDC need standard		
O	Medically needy income standard		
O	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.
O	The amount is determined using the following formula:		
O	Other (specify):		
X	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:*

X	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
O	The State does not establish reasonable limits.
O	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.	
○	The following formula is used to determine the needs allowance:			
○	Other (specify):			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:			
	Specify the amount of the allowance:			
	○	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)*			

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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 §435.726:**	
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-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. <u>Allowance for the spouse only</u> (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	○	The following standard under 42 CFR §435.121:	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount:	$ If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
○	Not applicable *(see instructions)*		

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

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		

○	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

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

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

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

i. 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
○	The following formula is used to determine the needs allowance:		
○	Other (*specify*):		
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*			
○	Allowance is the same		
○	Allowance is different. Explanation of difference:		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:			
a. Health insurance premiums, deductibles and co-insurance charges. b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*			
○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*		
○	The State does not establish reasonable limits.		
○	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.		

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

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

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

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):* 1	
ii.	**Frequency of services**. The State requires *(select one)*:	
	X	The provision of waiver services at least monthly
	O	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*):

O	Directly by the Medicaid agency
X	By the operating agency specified in Appendix A
O	By an entity under contract with the Medicaid agency. *Specify the entity*:
O	Other (*specify*):

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

Individuals performing initial level of care evaluations will be Utah licensed registered nurses employed by the operating agency.

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

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

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

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

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

The Operating Agency will provide for an evaluation (and periodic reevaluations) assessment using the standard waiver instrument, InterRAI MINIMUM DATA SET – HOME CARE (MDS-HC), described in Appendix B-6(e), to assess the level of care specified in item 1-F of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

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

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

The InterRAI MINIMUM DATA SET - HOME CARE (MDS-HC) is the instrument used to determine the level of care for this waiver. Persons responsible for collecting the needed information and for making level of care determinations are trained by staff, of the Division of Services for People with Disabilities (DSPD), in the proper application of the MDS-HC instrument and the proper analysis of the MDS-HC data to perform level of care evaluations.

The MDS-HC is a comprehensive, standardized instrument for evaluating the needs, strengths and preferences of clients of home care agencies. The MDS-HC also acts as a screening component that enables a home care provider to assess multiple key domains of function, health, social support and service use. Particular MDS-HC items identify clients who could benefit from further evaluation of specific problems and risk for functional decline. The MDS-HC has been designed to be compatible with the family of InterRAI assessment and problem identification tools, which includes the MDS (InterRAI Minimum Data Set) nursing home assessment instrument. Such compatibility promotes continuity of care through a seamless geriatric assessment system across multiple health care settings, and promotes a person-centered evaluation in contradiction to a site-specific assessment.

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

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

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

The State Operating Agency utilizes the following process to make level of care determinations as follows:

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

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

O	Every three months
O	Every six months
O	Every twelve months
X	Other schedule (*specify*):
	A full level of care reevaluation is conducted at a minimum within 12 consecutive months of the last recorded full level of care evaluation, or more frequently, whenever indicated by a significant change in the individual's health status. The individual's level of care is screened at the time a substantial change in the individual's health status occurs, including at the conclusion of an inpatient stay in a medical institution, to determine whether the individual's resultant health status constitutes an ongoing nursing facility level of care. The screening date and determination are documented in the individual's activity log.

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

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

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

The Utah Systems for Tracking Eligibility, Planning and Services (USTEPS), developed and maintained by the Division of Services for People with Disabilities, creates an automated tickler "to do" message that is sent 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 Utah Systems for Tracking Eligibility, Planning and Services (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 Uniplexed Information and Computing System (UNIX) backup occurs 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**	**Number and percentage of new enrollees who met level of care prior to receiving PD waiver services.**		
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*	
	X *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**	**Number and percentage of participants who received an annual level of care redetermination conducted at a minimum within 12 consecutive months of the last recorded level of care evaluation.**		
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)*
	☐ *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 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 nursing facility 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)*
	☐ *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:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure: **#3**	**Number and percentage of 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)*
	☐ *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*	

State:	
Effective Date	

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

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 individuals who conduct level of care evaluations and reevaluations who have a current Utah Registered Nurse license.**		
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*	**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:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure: #2	**Number and percentage of individuals whose level of care reevaluation was conducted during a face to face visit.**		
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)*
	☐ *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:*	

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

Individuals who request services from DSPD are screened for level of care for all waivers, ranked according to a critical needs assessment process and placed on the waiting list. When the individual is taken off the waiting list, the PD Administrative Case Manager determines if the individual needs services from the PD waiver program. For all individuals who have been taken off the waiting list and require services, an evaluation for level of care is conducted by the Administrative Case Manager. DSPD is the entity that will conduct level of care reviews. 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 five. A response distribution equal to 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

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 nursing facility 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	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and***

and Analysis (including trend identification)		***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:*

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 in the Care Plan.

Freedom of choice procedures:

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

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

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

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

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

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

The Freedom of Choice, documented in the Care Plan as part of the person centered support planning process, is maintained in the individual's case record maintained by the Operating Agency 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 State Medicaid Agency encourages clients to use professional services rather than relying on a family member or friend though the final choice is theirs. Using an interpretive service provider ensures confidentiality as well as the quality of language translation.

Information regarding access to Medicaid Translation Services is included in the Medicaid information booklet, "Exploring Medicaid," distributed to all Utah Medicaid recipients. Eligible individual may access translation services by calling the Medicaid Helpline.

For the full text of the "Exploring Medicaid" brochure, go to http://hlunix.ex.state.ut.us/medicaid/ and select the "Exploring Medicaid" hyperlink.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	X	Personal Attendant Services
Adult Day Health	☐	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	☐	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
O	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.	Personal Emergency Response System (purchase, testing, installation and service fees)
b.	Local Area Support Coordination Liaison

c.	
d.	
e.	
f.	
g.	
h.	
i.	

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)*:
a.	
b.	
c.	

Supports for Participant Direction *(check each that applies))*	
X	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
☐	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.
○	Not applicable

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

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

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

☐	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*.
X	As an administrative activity. *Complete item C-1-c.*
☐	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:

Administrative Case Management Services are provided by the Utah licensed registered nurses employed by the Operating Agency (DSPD).

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 through 122 and R501-14, of the Utah Human Services Administration, require all persons having direct access to children or vulnerable adults to undergo a criminal history/background investigation except in the case where the waiver enrollee has chosen to self-employ a family member as part of their self directed program. The Office of Licensing, an agency within the Utah Department of Human Services, has the responsibility of conducting background checks on all direct care workers who provide waiver services. The scope of the investigation includes a check of the State's child and adult abuse registries (maintained by The Utah Division of Child and Family Services and The Utah Division of Aging and Adult Services respectively), and a Criminal History check through the Criminal Investigations and Technical Services Division of the Department of Public Safety. If a person has lived outside the State of Utah or in any foreign countries for six or more consecutive weeks within the last five years, the FBI National Criminal History Records and National Criminal History will be accessed to conduct a check in those states and countries where the person resided. The Division of Services for People with Disabilities (DSPD) maintains a database on all approved employees. DSPD will not approve payments if the required screenings have not been completed. For providers under the Self Administered Service Model, the state will withhold payments for services for anyone who has not completed a background check within the first 30 days of being hired. The Division of Services for People with Disabilities (DSPD) has the ability to view the database of the Office of Licensing in regards to the status of employees hired under the self-administered model. All employees are required to renew their background checks on an annual basis. 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 State Medicaid Agency.
○	**No**. Criminal history and/or background investigations are not required.

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

X	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	UCA 62A-2-120 through 122 and R501-14, of the Utah Human Services Administration, require all persons having direct access to children or vulnerable adults to undergo an abuse screening 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 the Department of Human Services, Office of Licensing, completes all screenings. The Division of Services for People with Disabilities (DSPD) maintains a database on all approved employees. DSPD will not approve payments if the required screenings have not been completed.
○	**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.
X	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.*

The types of relatives to who payment is made: With the exception of parents of adult children who are only allowed to be paid under specific circumstances, there are no restrictions to payments made to relatives of the person.

Specific circumstances under which payment is made to a parent, step-parent of the person:

1. When a person lives in a rural area within five miles of a population center of less than 2,500 when there are no other resources to provide supports within a reasonable geographic area (15 miles) from the person and the person conducts on ongoing recruitment of resources other than a parent.
2. For the time when the parent who has specialized training for safely operating health related technology for the Person including but not limited to the operation of a ventilator, G peg tube feeding, home dialyses infusion, and wound care performs those tasks because the person can demonstrate they have no other dependable or qualified resources available to do so.
3. If the person is functionally quadriplegic and is dependent on others to perform health and safety related supports and other routine activities of daily living.
4. If the person needs supports critical to their health and safety during non-traditional work hours such as during the night.

Parents, Step-parents, may be paid to provide services under this waiver under the service of personal attendant. Please also see the full service description in appendix C-3.

Controls that are employed to ensure that payments are made only for services rendered:
In order for a parent, step parent to be paid under this waiver, he/she must meet all of the following authorization criteria and monitoring provisions;
- meet the criteria as outlined in the Personal Attendant Service
- the service must be specified in the consumers Person Centered Support Plan (PCSP)
- service must be paid at a rate that does not exceed that which would otherwise be paid to an employee
- time sheets and other required documentation must be submitted for hours paid.

Other monitoring requirements/provisions:
The below listed requirements apply to consumers electing to use parents, step-parents to be paid during specific circumstances;

	- monthly reviews by the FMS of hours billed for parents, step-parents care. These reviews will be overseen by the administrative nurse coordinators to ensure the appropriate usage and compliance with the billing process. -the administrative nurse coordinators will contact the person by phone or e-mail on at least a quarterly basis to identify the proper usage of and compliance with the program and to also ensure the persons health and safety as well as the status of the person and if the specific circumstance still applies. - the administrative nurse coordinator will conduct annual Self-Administered-Services Method (SAS) reviews and will review all of the required documentation that goes along with this method.
○	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
○	Other policy. *Specify*:

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

All Participants in the Physical Disability Program operated by DSPD are allowed to hire, train, and supervise employees to provide direct services.

Persons with physical disabilities hire staff ("Employee") 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*).

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

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

Quality Improvement: Qualified Providers

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

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

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 PD waiver providers that meet OA provider contract criteria.**		
Data Source • **Provider records** • **Provider staff 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*	**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:*	**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 participants who maintain accurate and updated personal attendant employee files.**		
Data Source • **Employee files** • **2-9C** • **2-9EA** • **2-9SA** • **Provider Code of Conduct** • **Background Check**	***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*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

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 participants who provided individual training to personal attendants.**		
Data Source • **Employee files** • **2-9C**	***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:*	

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 contract analysts conduct annual provider reviews of all programs that provide services to PD waiver participants. Monitoring includes all criteria specified in the provider contract. Administrative case managers monitor a sample of SAS employees on a monthly basis. The administrative case managers also complete a review checklist, which covers employee files, forms, and appropriate training for staff. Time sheets are reviewed to ensure proper billing for services. Administrative case managers meet in person with the participant to confirm the employees have received appropriate training. Both the administrative case managers and the USTEPS system track the expenditures for each participant and ensure that services remain within the allotted budget. 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 five. A response distribution equal to 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

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

and Analysis (including trend identification)		***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:*

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:	**Local Area Support Coordination Liaison**
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)**:**	
Local Area Support Coordination Liaison service involves: (a) assisting a waiver recipient to identify local area waiver services providers, community based resources, natural supports and to make informed choices when multiple options are available to fulfill the individual's plan of care; (b) establishing a periodic liaison schedule with the recipient as part of the individualized care plan based on assessed need for ongoing localized support; (c) providing the State Administrative RN Case Manager with routine recipient status updates on an ongoing basis, at a minimum of quarterly, and immediate notification in the event of substantial changes in the recipient's health, safety, local waiver program environment, or requests for changes in recipient services; and (d) participating in quality assurance evaluations of local waiver services, community based resources, natural supports and the waiver program as a whole, as it pertains to the local area.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Limitations: Limits on the amount, frequency and/or duration are specified on the individual's plan of care and based on assessed need.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Individual Medicaid provider contracted to provide Local Area Support Coordination Liaison service		Independent Living Centers	
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual			Under state contract with DSPD as an

			authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Medicaid provider contracted to provide Local Area Support Coordination Liaison service.
Agency Based			An organization structured as an Independent Living Center consistent with definitions and standards set forth in 29 USC Sec. 796a thru 796f. Medicaid provider contracted to provide Local Area Support Coordination Liaison service.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Local Area Support Coordination Liaison	Division of Services for People with Disabilities	Upon initial enrollment and annually thereafter.

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

Service Specification	
Service Title:	**Consumer Preparation Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
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)**:**	
Consumer Preparation Services are designed to ensure that waiver recipients are prepared to supervise and direct their personal assistance provider services. Consumer Preparation Services include: (a) instruction in methods of identifying need and effectively communicating those needs to service providers; (b) instruction in management of personal attendant(s) including interviewing, selecting, scheduling, termination, time sheeting, evaluating performance, back up coverage; (c)	

instruction in addressing problems such as changing levels of personal needs, grievance procedures, emergency coverage, exploitation and abuse. Consumer Preparation Services do not include educational, vocational or prevocational components.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limitations: Limits on the amount, frequency and/or duration are specified on the individual's plan of care and based on assessed need.

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Individual Medicaid provider contracted to provide Local Area Support Coordination Liaison service		Independent Living Centers	

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

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual			Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Medicaid provider contracted to provide Local Area Support Coordination Liaison service.
Agency Based			An organization structured as an Independent Living Center consistent with definitions and standards set forth in 29 USC Sec. 796a thru 796f. Medicaid provider contracted to provide Local Area Support Coordination Liaison service.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Consumer Preparation Services	Division of Services for People with Disabilities	Upon initial enrollment and annually thereafter

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

Elements of Personal Emergency Response Systems:

- Personal Emergency Response Systems (PERS) Response Center Service
  - Provides ongoing access to a signal response center that is staffed twenty-four hours per day, seven days a week by trained professionals responsible for securing assistance in the event of an emergency.

- Personal Emergency Response Systems (PERS) Purchase, Rental & Repair
  - Provides an electronic device of a type that allows the individual to summon assistance in an emergency. The device may be any one of a number of such devices but must be connected to a signal response center.

- Personal Emergency Response Systems (PERS) Installation, Testing & Removal
  - Provides installation, testing, and removal of the PERS electronic device by trained personnel.

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

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Personal Emergency Response System suppliers and response centers

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

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

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

Verification of Provider Qualifications

State:	
Effective Date	

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

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 Attendant 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)**:**

Personal Attendant Services are essential to help the waiver recipient achieve maximum independence and may vary depending on the needs of the individual and daily schedule. Services may include: (a) hands-on care of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. Skilled medical care and health maintenance may be provided only as permitted by State law and certified by the recipient's physician; (b) housekeeping, chore services and other reasonable and necessary activities which are incidental to the performance of the recipient's care may also be furnished as part of this service when agreed upon by the recipient, personal attendant and the case manager, as outlined in the plan of care. Payment to parents or step-parents, or legally responsible persons, can be made for personal attendant services deemed as extraordinary and as outlined in appendix C-2-e.

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

Limitations: Limits on the amount, frequency and/or duration are specified on the individual's plan of care and based on assessed need. Personal Attendant services are rendered in 15 minute units or at a daily rate. All instances in which Personal Attendant services are delivered for a period of eight hours or more within a day shall be billed using a daily rate rather than hourly rates for this service.

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	☐	Agency. List the types of agencies:
	Qualified individual selected by the recipient and has a joint DSPD contract/Medicaid Provider Agreement* * All providers receiving state funds appropriated to DSPD are required to enter into a state contract with the DSPD as a provider of services to persons with disabilities. The DSPD state contract is a document separate from the Medicaid Provider Agreement negotiated between each waiver provider and the SMA. A joint DSPD state contract/SMA Provider Agreement is in place for this service.			

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

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

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

Service Title:	**Financial Management Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
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 are offered in support of the self-administered services delivery option. Services rendered under this definition include those to facilitate the employment of personal attendants or assistants by the individual or designated representative including:

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 and to the Division of Services for People with Disabilities (DSPD).

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

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 R156-26A, UAC	Certified by the LTCB as an authorized provider of services and supports	• Under State contract with LTCB as an authorized provider of services and supports. • Comply with all applicable State and Local licensing, accrediting, and certification requirements. • Understand the laws, rules and conditions that accompany the use of State and local resources and Medicaid resources. • Utilize accounting systems that operate effectively on a large scale as well as track individual budgets. • Utilize a claims processing system acceptable to the Utah State Medicaid Agency. • Establish time lines for payments that meet individual needs within DOL standards. • Generate service management, and statistical information and reports as required by the Medicaid program. • Develop systems that are flexible in meeting the changing circumstances of the Medicaid program. • Provide needed training and technical assistance to clients, their representatives, and others. • Document required Medicaid provider qualifications and enrollment requirements and maintain results in provider/employee file. • Act on behalf of the person receiving supports and services for the purpose of payroll reporting.

			• Develop and implement an effective payroll system that addresses all related tax obligations. • Make related payments as approved in the person's budget, authorized by the case management agency. • Generate payroll checks in a timely and accurate manner and in compliance with all federal and state regulations pertaining to "domestic service" workers. • Conduct background checks as required and maintain results in employee file. • Process all employment records. • Obtain authorization to represent the individual/person receiving supports. • Prepare and distribute an application package of information that is clear and easy for the individuals hiring their own staff to understand and follow. • Establish and maintain a record for each employee and process employee employment application package and documentation. • Utilize and accounting information system to invoice and receive Medicaid reimbursement funds. • Utilize and accounting and information system to track and report the distribution of Medicaid reimbursement funds. • Generate a detailed Medicaid reimbursement funds distribution report to the individual Medicaid recipient or representative semi-annually. • Withhold, file and deposit FICA, FUTA and SUTA taxes in accordance with federal IRS and DOL, and state rules. • Generate and distribute IRS W-2's. Wage and Tax Statements and

			related documentation annually to all support workers who meet the statutory threshold earnings amounts during the tax year by January 31st. • File and deposit federal and state income taxes in accordance with federal IRS and state rules and regulations. • Assure that employees are paid established unit rates in accordance with the federal and state Department of Labor Fair Labor Standards Act (FLSA) • Process all judgments, garnishments, tax levies or any related holds on an employee's funds as may be required by local, state or federal laws. • Distribute, collect and process all employee time sheets as summarized on payroll summary sheets completed by the person or his/her representative. • Prepare employee payroll checks, at least monthly, sending them directly to the employees. • Keep abreast of all laws and regulations relevant to the responsibilities it has undertaken with regard to the required federal and state filings and the activities related to being a Fiscal/Employer Agent. • Establish a customer service mechanism in order to respond to calls from individuals or their representative employers and workers regarding issues such as withholding and net payments, lost or late checks, reports and other documentation. • Customer service representatives are able to communicate effectively in English and Spanish by voice and TTY with people who have a variety of disabilities.

			• Have a Disaster Recovery Plan for restoring software and master files and hardware backup if management information systems are disabled so that payroll and invoice payment systems remain intact. • Regularly file and perform accounting auditing to ensure system accuracy and compliance with general accounting practice.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Financial Management Services	Division of Medicaid and Health Financing, Long Term Care Bureau	Upon initial enrollment and annually 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*.
X	**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*.

	Utilizing the score derived from the Personal Assistance Critical Needs Assessment and the needs identified in the InterRAI MINIMUM DATA SET - HOME CARE (MDS-HC), the nurse case manager estimates the individual's prospective budget amount. These assessments function as a benchmark during the annual service planning process. The participant's needs, amount, frequency and duration of available services are discussed with the individual. An individualized waiver services budget is agreed upon. The participant decides how the funds should be allocated among the waiver services. The operating agency provides a central location for all nurse case managers in this waiver; they receive uniform training and engage in a cross review process; thus, assuring the budget process is applied consistently to all waiver recipients across the state. If at any time the individual's service needs change or a health and safety issue arises, the participant contacts their case manager regarding these changes. If the participant requests an increase in their services they may petition in writing for a change. The administrative case manager will complete a new MDS-HC, Critical Needs Assessment and review the present care plan. These documents are presented to The Division of Services for People with Disabilities' (DSPD) Associate Director for review. If additional funding is approved, the case manager notifies the participant; changes are made to the individual's service plan and the funding allocation plan to reflect the increase in funding. If the request is denied, the individual receives a Notice of Agency Action and information relating to their hearing rights. The process employed for determining individual budgets is open to public inspection during the development of the state implementation plan. During this time, the draft waiver implementation plan is made available to providers, recipients, the Indian Health Advisory Board, the Medical Care Advisory Committee and the public at large. The public is afforded the opportunity to provide feedback.
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
☐	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	

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)*:

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

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.

Prior to the development of the service plan the nurse case manager may refer the individual for Local Area Support Coordinator Liaison services or the individual may call or visit their local ILC (Independent Living Center). This provides the participant and/or family/legal representative with knowledge to identify the local community resources available, available local waiver service providers and natural supports in order for the

participant to make informed choices when multiple service options are available to fulfill the individualized care plan. Consumer Preparation services provide training to the participants to ensure they are prepared to recruit, supervise and direct their own personal assistance services to fulfill the individualized care plan.

The plan of care is developed by the recipient in consultation with the administrative case manager and others as necessary and appropriate. The participant has the authority to specify who participates in their care planning process.

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

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

a) Who develops the plan, who participates in the process, and the timing of the plan;
The administrative case manager has ultimate responsibility to develop the PCSP; however, it is the entire team's responsibility to participate. The team must consist of at least the participant, administrative case manger, 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 administrative case manager 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 PD waiver utilizes a comprehensive approach to service plan development. Important assessments include the Person- Centered Profile, medical assessment, the MDS-HC, and other therapy evaluations as needed and the review of the past year.

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

Prior to the initial planning meeting the participant is given a list of all the services provided on the PD waiver including the definition of each service. In addition, the list of PD services is found on the Division of Services for People with Disabilities (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 plan of care development process is based upon each participants identified and expressed needs, and strengths, as well as requirements for safe support in the community setting. The plan is created with the information gathered during the comprehensive assessment process using the MDS-HC, to identify health care needs, and participation from the individual on their choices. The Administrative Case Manager and the local area support coordinator liaison, through the Independent Living Centers (ILC's), assist participants to find out more information about individual providers. The waiver and non-waiver services are discussed with the individual, and based upon their preferences; the frequency, duration and choice of provider are identified and included in the plan.

(e) How waiver and other services are coordinated.

The coordination of the PDW and other services is a constant activity for the participant in services and the Administrative Case Manager. Through quarterly contact with the participant and through contact with the support coordinator liaison, the Administrative Case Manager is able to determine, which services are being used successfully, what new services may be needed, if services are being duplicated and what services may need to be reviewed for effectiveness.

The participant is also contacted by the local area support liaison as defined in the participants plan to ensure that the services being provided are appropriate to ensure a participants health and safety in the community. The local area support liaison at the ILC submits an activity log to the Administrative Case Manager. These documents keep the Administrative Case Manager informed about the individual's progress towards reaching their goals in the plan of care.

(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 PD waiver services, including details on amount, duration, and frequency. It also identifies supports and services, individuals who will be 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 PD waiver, the name of the contracted provider, the service code, and the requirement for support strategies are documented.

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

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

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

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

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

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

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 State Medicaid Agency (SMA) retains final authority for oversight and approval of the service planning process. The oversight function involves at a minimum an annual review of a sample of waiver enrollee's service plans that is representative of the caseload distribution across the program. The specific sample size of each review is selected based on the identified focus of the review and the number of reviews determined to be necessary to evaluate the waiver's performance. If the sample evaluation identifies system-wide service planning problems, an expanded review is initiated by the SMA.

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

O	Every three months or more frequently when necessary
O	Every six months or more frequently when necessary
O	Every twelve months or more frequently when necessary
X	Other schedule (*specify*):
	The plan of care will be reviewed as frequently as necessary, with a formal review at least every 12 months, completed during the calendar month in which it is due. Should the recipient experience a significant change in his/her health status, the administrative case manager or the recipient will initiate a review of the plan of care to assure appropriate services are defined to meet the recipient's care needs. The plan of care revisions will be completed in a time frame consistent with the nature of the change in status, but in no case will the time frame exceed 14 days from the date the administrative case manager was notified of the change in status. If the recipient was in an acute care facility, the plan of care will be reviewed within 7 business days from the date the administrative case manager was notified that the recipient returned to his/her place of residence.

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.

This waiver maintains a consumer driven focus, as such the consumer has a responsibility to identify areas of concern, and report problems to his/her administrative case manager. At a minimum, the administrative case manager and consumer shall have a face-to-face visit at least once every six months. Additional contacts will take place by phone on at least a quarterly basis.

The operating agency, the Division of Services for People with Disabilities (DSPD), is responsible for designing and implementing a quality management program. This program includes procedures for overseeing the performance of the needs assessment process, service plan development and implementation process.

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

Additionally, a three year trend report is generated for each participant. The administrative case manager and the participant go over this report annually to identify trends in utilization/expenditures in order to have the most accurate budget possible.

Activities conducted by the nurse case manager such as the review of monthly FMS statements, review of monthly provider summary notes, risk assessment and contingency plan development, annual satisfaction surveys and prompt response to waiver recipient's inquiries from the "front line" of service plan and health and welfare monitoring.

DSPD is responsible to organize the content and timeframes of its quality assurance program. Program performance reviews are to be done by DSPD staff that is not responsible for service planning and delivery to assess the accuracy and effectiveness of the link between the determination of need, the service plan, the implementation of case management services and the ongoing evaluation of progress towards the individual's stated goals.

At a minimum, an annual review will be conducted by DSPD utilizing an adequate sample to evaluate program performance.

All plans of care are subject to annual and periodic post-payment review and approval by the State Medicaid Agency (SMA). A sample of care plans will be reviewed each waiver year. Significant findings from those reviews will be reported to the operating agency. The operating agency will be required to develop a plan of correction with specific timeframes for completion. The SMA will conduct follow-up reviews 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 • **PCSP** • **Participant records** • **Support**	***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)*

Coordinator Liaison Monthly summaries • **Support Coordinator Liaison Action plan** • **Risk assessment**			
	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 participants for whom there is sufficient documentation to ascertain whether participants have made progress on goals identified on the PCSP and/or Action Plan.**		
Data Source • **Participant**	***Responsible Party for data collection/generation***	***Frequency of data collection/generation:*** *(check each that*	***Sampling Approach*** *(check each that applies)*

records • **PCSP** • **Support Coordinator Liaison Monthly summaries** • **Support Coordinator Liaison Action plan**	*(check each that applies)*	*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:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

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 participants for whom a risk assessment was updated annually.**		
Data Source • **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:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	☐ *Weekly*	
	X *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

State:	
Effective Date	

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 annually, completed during the calendar month in which it is due.**		
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*	

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

***Performance Measure:* #2**	**Number and percentage of PCSPs which are updated/revised when warranted by changes in the participant's needs.**		
Data Source • **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*	
		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:*	

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 participants who received services in accordance with their PCSP including the type, amount, frequency and duration.**		
Data Source • **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*	
		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*	

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

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 between nursing facility care and PD waiver services.**		
Data Source • **PCSP**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	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 participants who are made aware of all services available on the PD waiver.**		
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*	

State:	
Effective Date	

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

***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:*	**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.*

PCSPs are developed 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. 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 nursing facility care or PD waiver services and choice is documented on the PCSP. Participants are made aware of all services available on the PD waiver and are offered choice among providers whenever choice exists. 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 five. A response distribution equal to 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

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:*	**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 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.

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

The self administered services method necessitates the use of Financial Management Services (FMS), commonly known as a "Fiscal Agent", to assist with managing employer-related financial responsibilities associated with self administered services. These employer-related financial responsibilities include federal, state, and local tax withholding/payments, fiscal accounting, expenditure reports, Medicaid claims processing and reimbursement distribution.

If the needs assessment process has indicated the waiver participant would benefit from access to Consumer Preparation and Local Area Support Liaison services, the nurse case manager will refer them to a provider qualified to provide the knowledge base for the individual to successfully direct their personal attendance services in their local area.

The participant has budget authority as it pertains to their personal assistance staff. The recipient decides how many employees they can afford to hire within the overall budgeted

amount, the wages to be paid and the amount of hours worked. They are responsible to review all employee timesheets for accuracy and submit them to the FMS agent for payment. The FMS agent sends the employer information after each pay period detailing what was paid and the amount remaining in their budget.

Waiver participants 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*).

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

A copy of the individual's support plan/approved budget worksheet will be given to the chosen provider of FMS. 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 FMS providers under contract with the Division of Services for People with Disabilities (DSPD). Payments are not issued to the waiver recipient, but to and in the name of the employee that was hired. The person will be authorized for a rate to cover the costs of the employee wages and benefits reimbursement.

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

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

○	**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.
X	**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):*

X	Waiver is designed to support only individuals who want to direct their services.
○	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

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)*:

X		The State does not provide for the direction of waiver services by a representative.
○		The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:
	○	Waiver services may be directed by a legal representative of the participant.
	○	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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
Personal Attendant Services	X	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 services.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
	Not applicable. FMS is not an administrative function.	
ii.	**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):*

Financial Management Services (FMS) 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 an FMS provider, including all tax forms (IRS Forms I-9, W-4 and 2678), payroll schedule, FMS provider's contact information and training material for the web-based timesheet.

4. Process and pay Utah Department of Human Services/Division of Services for People with Disabilities 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 FMS provider.

6. Maintain a customer service system for persons and employees who may have billing questions or require assistance in using the web-based timesheet. The FMS provider will maintain an 800-number for calls received outside the immediate office area. Messages must be returned within 24 hours Monday thru Friday. Messages left between noon on Friday and Sunday evening shall be returned the following Monday.

a. Must have capabilities in providing assistance in English and Spanish. Fiscal Agent must also communicate through TTY, as needed, for persons with a variety of disabilities.

7. File consolidated payroll reports for multiple employers. The FMS provider must obtain federal designation as FMS provider under Internal Revenue Services' (IRS) Rule 3504 (Acts to be Performed by Agents). An FMS provider must make an election with the appropriate IRS Service Center via Form 2678 (Employer Appointment of Agent). The FMS provider must carefully consider if they want to avail the Employers of the various tax relief provisions related to domestics and family employers. The FMS provider may forego such benefits to maintain standardization. Treatment on a case-by-case basis is tedious, and would require retroactive applications and amended employment returns. The FMS provider will, if required, comply with IRS Regulations 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 FMS provider to file one employment tax return, regardless of the number of employers they are acting for, provided the FMS provider has a properly executed Form 2678 from each Employer. 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 FMS provider.

8. Obtain IRS approval for Agent status. The FMS provider shall consolidate the federal filing requirements, obtain approval for Utah State Tax Commission consolidated filings, and obtain approval for consolidated filing for unemployment insurance through the Department of Workforce Services. For those Employers retaining domestic help less than 40 hours per week, Workers Compensation coverage is optional. If the 40-hour threshold is achieved or exceeded, the Worker's Compensation Act requires coverage. Statutory requirements and the nature of insurance entail policies on an individual basis. Consolidated filings of Workers Compensation are not an option.

9. The FMS provider cannot provide waiver recipients with community-based services in addition to FMS.

Supports furnished when the participant exercises budget authority:

☐	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, administrative case managers and others, who assist in the development and delivery of supports for people served through the Division of Services for People with Disabilities (DSPD), 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 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 Self Administered Services (SAS) service delivery through standardized, mandatory training & manuals for SAS families and administrative case managers, development of the Family to Family Network, and a formal documentation monitoring tool used by administrative case managers 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)*:

☐	**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:*	
X	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:	Consumer Preparation Services, Financial Management Services and Local Area Support Coordination Liaison
X	**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:*	
	The State/Regional Administrative Waiver Case Manager, as an employee of the Division	

of Services for People with Disabilities (DSPD), is responsible to oversee and/or perform the following essential activities directly connected to ensuring the proper and efficient operation of the Medicaid home and community-based waiver for individuals with severe physical disabilities:
· Compile, coordinate and forward (to Medicaid's Eligibility Services and Long Term Care Bureau respectively) necessary documentation to support timely medical and Medicaid eligibility determination for waiver applicants and recipients;
· Oversee and actively participate in the plan of care process and periodically monitor the delivery of services;
· Assist recipients to obtain and maintain needed Medicaid (state plan and waiver) benefits;
· Regularly evaluate the effectiveness of the waiver;
· Monitor, evaluate, train and when appropriate, delegate medical assistance services to personal attendants (only as authorized by the recipient's physician and in accordance with state laws);
· Provide consultation to Local Area Support Coordination Liaisons about waiver recipient issues and waiver service delivery.
· Supervise waiver-related activities of Local Area Support Coordination Liaisons.
· Coordinate with the state Medicaid agency to recommend modifications to policies, procedures and standards;
· Design/provide/arrange as appropriate, the delivery of provider training and instruction;
· Conduct provider recruitment and oversight/Quality Assurance activities. Identify and assist qualified individuals and agencies to enroll as providers of waiver services;
· Conduct outreach activities to identify and inform potential recipients, their families and interested others in the community about the waiver program;
· Ensure applicant/recipient rights, including rights to fair hearing;
· Oversee development and implementation of fee schedule criteria and protocols;
· Maintain and manage waiting list;
· Coordinate waiver services with enrolled Medicaid Nursing Facilities; develop and implement procedures and protocols to facilitate clients' transition between nursing facilities and community-based settings;
· Develop and implement internal quality assurance protocols; participate in joint program reviews with the state Medicaid agency;
· Compile information, data and reports to support the above functions and as required by the state Medicaid agency and CMS;
· Other duties as jointly agreed to by the state Medicaid agency and the Division of Services for People with Disabilities and covered in the interagency agreement.

QUALIFICATIONS
· Licensed in the State of Utah as a Registered Nurse in accordance with Title 58, Occupational and Professional Licensing, Utah Code Annotated, 1953 as amended; and
· One year of paid professional experience in working with individuals with severe physical disabilities. Preference given to applicants with one year of direct nursing services with individuals with severe physical disabilities

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:

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

The Division of Medicaid and Health Financing (DMHF) in partnership with the Division of Services for People with Disabilities (DSPD) will compile information on voluntary disenrollments.

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.

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

Special circumstance disenrollments entail such cases that are non-routine in nature and involve circumstances that are specific to the individual involved.

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

Table E-1-n		
	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	150	150
Year 2	150	150
Year 3	150	150
Year 4 (renewal only)	150	150
Year 5 (renewal only)	150	150

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
X	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, Division of Services for People with Disabilities, 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
X	Determine the amount paid for services within the State's established limits
X	Substitute service providers
X	Schedule the provision of services
X	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
X	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
X	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
X	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.

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

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

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

Once the draft plan is drawn up, the nurse coordinator communicates the amount budgeted for each type of service included in the plan.

Each month the person receives a report from the Financial Management Services l agent that provides information on the amount of budget used and remaining. The participant can also contact the nurse coordinator at anytime to find out the current balance of the budget. The nurse coordinator reviews what has been spent each month and monitors whether the plan needs any adjustments due to crisis, loss of caregiver or other deterioration in participant functioning.

If at any time the individual's service needs change or a health and safety issue arises, the participant is responsible to contact their administrative case manager with these changes. If the participant requests an increase in their services, they may petition in writing for additional funds. The administrative case manager will complete a new MDS-HC, Critical Needs Assessment and review the present care plan. These documents are presented to the Division of Services for People with Disabilities Associate Director for review.

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

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:
X	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:

Each month the administrative case manager reviews the billing statement from the Financial Management Services provider and a monthly budget sheet from the operating agency's financial analyst. If these documents reveal over/under utilization, the case manager contacts the participant to discuss the reasons why and revise the budget if necessary. Additionally, a three year trend report is generated for each participant. The administrative case manager and the participant go over this report annually to identify trends in utilization/expenditures in order to have the most accurate budget possible.

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 their representative (if applicable), will receive a written Notice of Agency Action, Form 522 and a Hearing Request Form 490S from a Division of Services for People with Disabilities (DSPD) administrative case 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 Department of Human Services, which is dispositive. The person may request assistance from the Disability Law Center, Utah's statutory protection and advocacy organization, or 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.

The waiver individual support plan serves as the formal document identifying services that the waiver enrollee receives based on the comprehensive needs assessment. At the time a substantial change in a waiver enrollee's condition results in a change in the person's assessed needs, the individual support plan is revised to reflect the types and levels of service necessary to address the current needs. If the revisions to the individual support plan result in termination of a covered waiver service, reduction in the waiver services being received, or denial of services felt to be necessary to prevent institutionalization, the individual has the right to appeal the decision to revise the individual support plan. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions, but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing (Form 490S) and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

2. SINGLE STATE AGENCY

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

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

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

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

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

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

Appendix F-2: Additional Dispute Resolution Process

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

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

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

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

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

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

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

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

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

DSPD Policy 1.11 Conflict Resolution requires the administrative case manager to provide information to recipients on the conflict resolution process and on how to contact the administrative case manager's supervisor. The supervisor reviews all complaints submitted either orally or written and any relevant information submitted with the complaint. The supervisor will take appropriate action to resolve the dispute and respond to all parties concerned. If the parties are unable to resolve the dispute either party may appeal to the Region Director. The Region Director will meet with the parties and review any evidence presented. The Region Director shall determine the best solution for the dispute. The Region Director will prepare a concise written summary of the finding and decision and send it to the parties involved. Either party may request an independent review if they do not agree with the Region Director's decision. Based on interviews with the parties and a review of the evidence, the independent reviewer will prepare for the Division Director a written summary of the factual findings and recommendations. Based on the independent reviewers report the Division Director will determine the appropriate resolution for the dispute and shall implement any necessary corrective action.

Appendix F-3: State Grievance/Complaint System

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

X	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

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

The Utah Department of Human Services, Division of Services for People with Disabilities, and the Utah Department of Health, Division of Medicaid and Health Financing, Long Term Care Bureau

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 Utah Department of Human Services (DHS)/Division of Services for People with Disabilities (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 DHS and the Utah Department of Health (DOH) have constituent services available. Participants may call and verbally register a complaint/grievance. The constituent services representative ensures the caller is referred to the appropriate party for problem resolution.

The types of complaints that can be addressed through the grievance/complaint system include but are not limited to: Complaints about a provider of waiver services, complaints about the way in which providers deliver services, complaints about individual personnel within a provider agency, 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 Long Term Care Bureau investigates complaints/grievances that are reported to the State Medicaid Agency (SMA) and pertain to the operation of the Physical Disabilities waiver. The SMA makes all efforts to resolve the complaint/grievance to the satisfaction of all parties within two weeks of the submission of the complaint/grievance. Some complaints/grievances may require additional time to investigate and implement a resolution. Findings and resolutions of all complaints/grievances are documented by fiscal year in the SMA complaint/grievance data base.

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

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 (Utah Department of Health) Critical Event or Incident Reporting Requirements:

The State Medicaid Agency (SMA) requires that the Division of Services for People with Disabilities' (DSPD) administration report critical events/incidents on the first business day after the event that occurs either to or as a result of 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 administrative 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 Utah Department of Human Services/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.

When a participant is admitted to the waiver and on a quarterly basis, thereafter, by phone or in person, the Administrative Case Managers will review with the participant what constitutes a reportable incident and encourage the participant to report incidents to the Administrative Case Manager and/or the Support Coordinator Liaison as soon as possible after the occurrence of the incident. In addition, during scheduled contacts with the participant, as described within this application, the Administrative Case Manager and the Support Coordinator Liaison must inquire if any incidents have occurred to the participant and document the response in the participant record. If an incident has occurred the DSPD Incident Report Form 1-8 must be completed within 5 days.
The Administrative Case Manager will provide the participant with the DSPD Incident Report Form 1-8 and encourage the participant to fill out and submit this form to the Administrative Case Manger within 5 days of the incident. If the participant is not able to complete the Incident Report Form, the participant (or participant representative) may contact the Administrative Case Manager or the Support Coordinator Liaison to complete the form.

Within 24 hours after the Support Coordinator Liaison discovers an incident has occurred to a participant, the Support Coordinator Liaison must either notify the Administrative Case Manager by telephone, email or fax or assure that the participant has made the notification. The Support Coordinator Liaison must then complete the DSPD Incident Report Form 1-8 and submit it to the Administrative Case Manager within 5 days or assure that the participant has completed and submitted the form.

The administrative case manger 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.

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.

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

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

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

Responsibility of the State Medicaid Agency (SMA)

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 also report these instances to the SMA within 48 hours.

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

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

Oversight Responsibility of Critical Incidents/Events of the State Medicaid Agency (SMA):

The SMA reviews 100% of critical incident reports, annually. The SMA also reviews the Division of Services for People with Disabilities' (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):*

X	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:
	The State Medicaid Agency (SMA) monitors for the use of any restraints or seclusion 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 any incidents involve the use of restraints or seclusion. 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/Event Incident Notification system that requires the Division of Services for People with Disabilities to notify the SMA of any serious incidents including the use of restraints or seclusion that are reported as part of critical incident notifications. The Operating Agency also verifies that there is no use of restraints or seclusion when conducting on site visits and performing annual reviews. Any incidents involving the use of restraints or seclusion would be immediately reported to Adult Protective Services. Administrative case managers have the day to day responsibility to assure that there are no incidents involving the use of restraints or seclusion.
○	The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

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

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

b. Use of Restrictive Interventions

X	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:
	The State Medicaid Agency (SMA) monitors for the use of any 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 any incidents involve 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/Event Incident Notification system that requires the Division of Services for People with Disabilities to notify the SMA of any serious incidents including the use of restrictive interventions that are reported as part of critical incident notifications. The Operating Agency also verifies that there is no use of restrictive interventions when conducting on site visits and performing annual reviews. Any incidents involving the use of restrictive interventions would be immediately reported to Adult Protective Services. Administrative case managers have the day to day responsibility to assure that there are no incidents involving the use of restrictive interventions.
○	The use of restrictive interventions is permitted during the course of the delivery of waiver services. Complete Items G-2-b-i and G-2-a-ii:

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

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

Appendix G-3: Medication Management and Administration

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

a. Applicability. Select one:

○	**Yes**. This Appendix applies *(complete the remaining items)*.
X	**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.

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

c. Medication Administration by Waiver Providers

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

○	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).

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

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

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.

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: **Health and Welfare**
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

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

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

***Performance Measure:* #1**	**Number and percentage of suspected abuse, neglect or exploitation incidents referred to Adult Protective Services, and/or law enforcement, as required by 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:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

***Performance Measure:* #2**	**Number and percentage of participants who have been informed of the OA incident reporting requirements, at a minimum of annually.**		
Data Source • **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*	**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:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

***Performance Measure:* #3**	**Number and percentage of incidents (as defined in R539-5-6) reported to the Administrative Case Manager within 24 hours by phone, email or fax.**		
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)*

• **Provider records** • **Provider interviews**			
	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:* #4**	**Number and percentage of incidents (as defined in R539-5-6) for which form 1-8 (Incident Report form) was submitted to or completed by the Administrative Case Manager 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*	☐ *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:* #5**	**Number and percentage of incidents for which prevention strategies were developed and implemented (when warranted).**		
Data Source • **Participant records** • **PCSP** • **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:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure: **#6**	**Number and percentage of participants who have an adequate back-up plan for the provision of essential services.**		
Data Source • **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:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

***Performance Measure:* #7**	**Number and percentage of incidents/events that met the SMA critical incidents/event criteria that were reported to the SMA.**		
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*
	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:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance	**Number and percentage of letters notifying the**

Measure: #8	**participants/representatives of the results of the critical incident/event investigation within two weeks of the closure of the case by the SMA as per critical incident/event protocol.**		
Data Source • **Critical Incident 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)*
	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*	
	☐ *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.*

Referrals are made to Adult 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, the participant must notify the administrative case manager by phone, email or fax within twenty-four hours of the occurrence. In addition, the participant, personal attendant, administrative case manager or support coordinator liaison must document the details of the incident on Form 1-8. If the Form 1-8 is completed by someone other than the administrative case manager, it must be then submitted to the administrative case manager 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. When a fatality occurs, the Fatality Review Committee reviews the death and submits a written report to DSPD. If follow up is required, DSPD shall 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. DSPD 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 five. A response distribution equal to 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

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 and direct care provider agencies, such as home health and/or hospice agencies, requiring an immediate review and remediation of the issue, reporting the issue to Utah Adult 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:*	**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 Health and Welfare that are currently non-operational.

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

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

Appendix H: Quality Improvement Strategy

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

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

Appendix H-1: Systems Improvement

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

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

a.ii.

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

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

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

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 PD waiver. Improvements to the QIS will be made at this time and submitted in the following waiver renewal application.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

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

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

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

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

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

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

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

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

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

STATE MEDICAID AGENCY ROLE AND PROVIDER CONTRACT REQUIREMENT

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

JOINT DSPD STATE CONTRACT/SMA PROVIDER AGREEMENT

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

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** • **PCSP** • **Participant budgets** • **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*	***Frequency of data aggregation and analysis:*** *(check each that*	

	applies	*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** • **Participant budgets**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *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*	
		☐ *Other: Specify:*	

***Performance Measure:* #4**	**Number and percentage of provider claims submitted and processed through the USSDS which match the DSPD claims submitted and processed through the MMIS.**		
Data Source • **USSDS claims payment history report** • **MMIS claims payment history report**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval = 5*
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

***Performance Measure:* #5**	**Number and percentage of incorrectly billed claims that are recovered and processed correctly through MMIS.**

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:*	

Performance Measure: #5	**Number and percentage of overpayments that are returned to the federal government within required time frames.**		
Data Source • **Participant**	***Responsible Party for data collection/generation***	***Frequency of data collection/generation:*** *(check each that*	***Sampling Approach*** *(check each that applies)*

claims data • **SMA QA review** • **CMS 64 report**	*(check each that applies)*	*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 PD waiver 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 five. A response distribution equal to 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response

distribution used for further reviews will reflect the findings gathered during the base line review.

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:*	**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 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).

The State Medicaid Agency (SMA) has reviewed the Physical Disabilities (PD) waiver rates and the rate setting methodologies. Below is a list of the services and the rate information:

The following service is rebased annually:
Local Area Support Coordination Liaison

The following services were rebased in 2005 and have received COLA adjustments:
Financial Management Services
Personal Assistance Services

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):
Consumer Preparation Services

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

Although a competitive contracting process was used in the initial setting of the rate for PERS, the services may be provided by all enrolled, qualified providers who are willing to accept the rate.

The process employed for describing waiver rate setting methodology is open to public inspection during the development of the state implementation plan. During this time, the draft waiver implementation plan is made available to providers, recipients, the Indian Health Advisory Board, the Medical Care Advisory Committee and the public at large. The public is afforded the opportunity to provide feedback.

All rates will be rebased at least once during the five year waiver renewal period.

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 the Utah Department of Human Services (DHS)/Division of Services for People with Disabilities (DSPD):

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

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

For providers who bill the Medicaid Management Information System (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 Participant Centered Service Plan (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.

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 USSDS (Utah Department of Human Services provider payment system) and MMIS contain edits to help ensure that no payment is ever rendered to Medicaid ineligible recipients or providers. USSDS 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 USSDS to MMIS for FFP reimbursements. DHS/DSPD providers are paid through USSDS, 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 State Medicaid Agency will perform an annual post payment review of claims that are paid to providers through the USSDS. The review will verify that the rates paid to

providers through the USSDS are equal to the rates paid to DSPD through the MMIS.

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

The Support Coordination Liaison and nurse coordinator are responsible to have frequent and ongoing interactions with waiver participants and are expected to monitor service utilization and assure services provided continue to meet the individual's needs on an ongoing basis.

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

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. However, for providers that voluntarily reassign payment to the Department of Human Services (DHS), initially payments for waiver services are paid to providers through the Department of Human Services (DHS), Unified Social Services Delivery System (USSDS).

(b) The process for making such payments and the entity that processes payments-

Waiver services providers bill the DHS using a paper claim that is entered into the USSDS system. The USSDS system has edits in place that will deny payment for reasons such as exceeding the maximum allowable number of approved units or maximum allowable rates, etc. Providers are reimbursed by DHS with either a paper check or an electronic funds transfer as per the provider's preference. DHS then submits a tape of all claims paid through the USSDS to the SMA. The claims are then entered into the MMIS for payment. The SMA makes payment to DHS through an 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 through the USSDS.

(d) The basis for the draw of federal funds and claiming of these expenditures on the CMS-64-

As stated previously all waiver service payments are eventually made through an approved Medicaid Management Information System (MMIS) and this is the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.

USSDS 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 the Utah Systems for Tracking Eligibility, Planning and Services (USTEPS) by case managers and result in payment authorizations in USSDS. 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.
○	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 Utah Department of Human Services (DHS)/Division of Services for People with Disabilities (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 Utah Department of Health (DOH) for reimbursement. The DHS Form 520 is a paper billing invoice form that is either generated by the Unified Social Services Delivery System (USSDS) 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 USSDS system receive payment that is equal to the payment DSPD receives from DOH including a comparison of DOH's MMIS Reference File rates with DSPD's USSDS rates for the same service, as per the DOH rate sheet provided each year. A comparison of MMIS HCPCS code/rate information with corresponding USSDS service code/rate information is implemented and documented via screen prints on a copy of a rate chart spreadsheet. This is completed before the beginning of each fiscal year when rates are generally adjusted, but a periodic review of USSDS to MMIS rates is completed throughout the year. Post rate adjustment billing detail is reviewed closely to ensure the agreed rates are correct on the claims submitted for reimbursement, as is the claims reimbursement detail.

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

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 USSDS 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.

	DSPD also informs providers of the process for billing the Medicaid Agency directly by sending out a letter to notify providers of this option.
☐	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.*

○	**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.*
X	**No**. State or local government providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

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

○	The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
○	The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the

	aggregate exceed its reasonable costs of providing waiver services.
○	The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

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 Utah 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 Utah 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 Utah Department of Human Services by the legislature. The Division of Services for People with Disabilities (DSPD), which resides within the Utah 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:

☐	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:
X	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

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

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

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

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

X	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*).
O	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:

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

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

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
X	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

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

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

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

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

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

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

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

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

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

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

X	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded~~;~~ and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care *(specify)*:			Nursing Home				
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$18,411	$18,017	$36,428	$56,023	$6,851	$62,874	$26,446
2	$18,785	$18,378	$37,163	$57,144	$6,988	$64,132	$26,969
3	$19,159	$18,745	$37,904	$58,287	$7,128	$65,415	$27,511
4	$19,534	$19,120	$38,654	$59,452	$7,271	$66,723	$28,069
5	$19,910	$19,502	$39,412	$60,641	$7,416	$68,057	$28,645

Appendix J-2 - Derivation of Estimates

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

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Nursing Facility	
Year 1	150	150	
Year 2	150	150	
Year 3	150	150	
Year 4 (renewal only)	150	150	
Year 5 (renewal only)	150	150	

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) = 335 days
- Used the average annual LOS count for fiscal year 2009 (2005 - 2009)

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

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

- All calculations are based off the actual amounts for FY2009, from the 372 report
- Price per unit was increased 2% each year.
- Units Per User is the average units per user for FY2009 rounded to the next whole number

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

- All calculations are based off the actual amounts for FY2009
- Average cost per enrollee was increased by 6% for the first year to account for FY2010-2012 increases. Each subsequent year was increased 2%
- The state utilizes the MMIS Categories of Service and Provider Type functionality to account for and exclude the costs of prescribed drugs from D'

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

- Used actual average nursing home cost per day for FY2009 (Last complete reporting period) and multiplied by actual PD waiver LOS to get fiscal year FY2009 base estimate and the increased by 6% to get Waiver year one (fiscal year 2012).
- Each subsequent year was increased 2%

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

- Used actual average nursing home cost per day for FY2009 (Last complete reporting period) and multiplied by actual PD waiver LOS to get fiscal year FY2009 base estimate and the increased by 6% to get Waiver year one (fiscal year 2012).
- Each subsequent year was increased 2%

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

X	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
O	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**
Consumer Prep Service, 15 Minute	15 Minute	10	5	$5.44	$272
Emergency Response System, Purchase	Per Episode	10	1	$226.00	$2,260
Emergency Response System, Per Month	Per Month	75	11	$39.00	$32,175
Personal Emergency Response Systems, Installation & Testing	Per Episode	15	1	$50.00	$750
Personal Attendant Care Services, Per 15 Minute	15 Minute	145	6000	$2.89	$2,514,300
Personal Attendant Care Services, Daily	Per Day	5	100	$92.38	$46,190
Financial Management Services, Per Month	Per Month	150	11	$39.00	$64,350
Support Coordinator Liaison, Per 15 Minute	15 Minute	100	30	$15.10	$45,300
GRAND TOTAL:					$2,705,597
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					150
FACTOR D (Divide grand total by number of participants)					$18,037
AVERAGE LENGTH OF STAY ON THE WAIVER					335

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**
Consumer Prep Service, 15 Minute	15 Minute	10	5	$5.55	$278
Emergency Response System, Purchase	Per Episode	10	1	$230.52	$2,305
Emergency Response System, Per Month	Per Month	75	11	$39.78	$32,819
Personal Emergency Response Systems, Installation & Testing	Per Episode	15	1	$51.00	$765
Personal Attendant Care Services, Per 15 Minute	15 Minute	145	6000	$2.95	$2,566,500
Personal Attendant Care Services, Daily	Per Day	5	100	$94.23	$47,115
Financial Management Services, Per Month	Per Month	150	11	$39.78	$65,637
Support Coordinator Liaison, Per 15 Minute	15 Minute	100	30	$15.40	$46,200
GRAND TOTAL:					$2,761,619
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					150
FACTOR D (Divide grand total by number of participants)					$18,411
AVERAGE LENGTH OF STAY ON THE WAIVER					335

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Consumer Prep Service, 15 Minute	15 Minute	10	5	$5.66	$283
Emergency Response System, Purchase	Per Episode	10	1	$235.13	$2,351
Emergency Response System, Per Month	Per Month	75	11	$40.58	$33,479
Personal Emergency Response Systems, Installation & Testing	Per Episode	15	1	$52.02	$780
Personal Attendant Care Services, Per 15 Minute	15 Minute	145	6000	$3.01	$2,618,700
Personal Attendant Care Services, Daily	Per Day	5	100	$96.11	$48,055
Financial Management Services, Per Month	Per Month	150	11	$40.58	$66,957
Support Coordinator Liaison, Per 15 Minute	15 Minute	100	30	$15.71	$47,130
GRAND TOTAL:					$2,817,735
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					150
FACTOR D (Divide grand total by number of participants)					$18,785
AVERAGE LENGTH OF STAY ON THE WAIVER					335

Waiver Year: Year 4					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Consumer Prep Service, 15 Minute	15 Minute	10	5	$5.77	$289
Emergency Response System, Purchase	Per Episode	10	1	$239.83	$2,398
Emergency Response System, Per Month	Per Month	75	11	$41.39	$34,147
Personal Emergency Response Systems, Installation & Testing	Per Episode	15	1	$53.06	$796
Personal Attendant Care Services, Per 15 Minute	15 Minute	145	6000	$3.07	$2,670,900
Personal Attendant Care Services, Daily	Per Day	5	100	$98.03	$49,015
Financial Management Services, Per Month	Per Month	150	11	$41.39	$68,294
Support Coordinator Liaison, Per 15 Minute	15 Minute	100	30	$16.02	$48,060
GRAND TOTAL:					$2,873,899
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					150
FACTOR D (Divide grand total by number of participants)					$19,159
AVERAGE LENGTH OF STAY ON THE WAIVER					335

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**
Consumer Prep Service, 15 Minute	15 Minute	10	5	$5.89	$295
Emergency Response System, Purchase	Per Episode	10	1	$244.63	$2,446
Emergency Response System, Per Month	Per Month	75	11	$42.22	$34,832
Personal Emergency Response Systems, Installation & Testing	Per Episode	15	1	$54.12	$812
Personal Attendant Care Services, Per 15 Minute	15 Minute	145	6000	$3.13	$2,723,100
Personal Attendant Care Services, Daily	Per Day	5	100	$99.99	$49,995
Financial Management Services, Per Month	Per Month	150	11	$42.22	$69,663
Support Coordinator Liaison, Per 15 Minute	15 Minute	100	30	$16.34	$49,020
GRAND TOTAL:					$2,930,163
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					150
FACTOR D (Divide grand total by number of participants)					$19,534
AVERAGE LENGTH OF STAY ON THE WAIVER					335

State:	
Effective Date	