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 waivers 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.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

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

-limitations to service codes and updates to service scope of work
-licensure requirements
-adjustments to community transition services
-removal of attendant training services
-addition of GPS for SMESAT & requirements for authorization/use of devices
-supplemental meals (pre-packaged)/licensure requirements
-provider enrollment information updated
-eligibility updates to describe continued program enrollment when out-of-state stays exceed 90 days
-application updates to include changes in terminology and processes

-Reduced number of participants (Factor C/Point in Time) to the levels prior to the temporary funding increase. There is no expected impact to current participants.

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

1. Request Information (1 of 3)

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

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

Waiver for Individuals Age 65 or Older

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: UT.0247
Waiver Number:UT.0247.R06.00
Draft ID: UT.009.06.00

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

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

07/01/20

Approved Effective Date: 07/01/20

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

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)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§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:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **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.

The purpose of the waiver for Individuals Age 65 or Older (thereafter referred to as the Aging Waiver) is to offer services to individuals age 65 or older that meet the eligibility criteria of the waiver. The waiver gives this population the option to remain in a home and community based setting of their choice rather than a facility.

The Department of Health, Division of Medicaid and Health Financing, is the Administrative Agency for this waiver while the Department of Human Services, Division of Aging and Adult Services (DAAS), is the Operating Agency (OA). The functions of both of these agencies are specified in Appendix A of this application. DAAS in turn contracts with eleven Area Agencies on Aging (AAA) to assist them in their activities.

The Aging Waiver offers both consumer directed services, as well as the traditional method of service delivery.

The Point In Time Limit will decrease over the course of WY3 based on attrition. Participants will not be discharged from the waiver in order to meet point-in-time estimates.

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*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

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)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

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

- (●) **No**
- ( ) **Yes**

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.
Specify 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 Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and

improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

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

The SMA together with the Division of Aging and Adult Services (DAAS) prepared an initial draft of the waiver renewal application in September 2019. The SMA and DAAS then convened a workgroup in December 2019 to discuss potential improvements and updates to the Waiver program. Updates to the renewal application were then crafted based on feedback from the workgroup.

Beginning February 26, 2020, and for 30 days thereafter, a copy of the draft State Implementation Plan was posted online at http://medicaid.utah.gov/ltc. Public comment was accepted by mail, fax and online submission. In addition, the State presented information on the waiver amendment to the Utah Indian Health Advisory Board (UIHAB) on January 10, 2020. The UIHAB represents all federally recognized Tribal Governments within the State. Additionally, a summary of the changes was supplied to the Medical Care Advisory Committee (MCAC) during their December meeting. Information on the renewal was published in the newspaper with instructions on how a copy of the implementation plan could be requested and how comment may be submitted. Hard copies were also made available at the Department of Health. The State did not receive any comments.

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 is 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:

Last Name: Bagley

First Name: Kevin

Title: Director, Bureau of Long-Term Services and Supports

Agency: Department of Health, Division of Medicaid and Health Financing

Address: PO Box 143112

Address 2:

City:

Salt Lake City

State: **Utah**

Zip:

84114-3112

Phone:

(801) 538-9144 **Ext:** ☐ **TTY**

Fax:

(801) 538-6412

E-mail:

klbagley@utah.gov

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

Last Name:

Holmgren

First Name:

Nels

Title:

Director

Agency:

Division of Aging and Adult Services

Address:

195 North 1950 West

Address 2:

City:

Salt Lake City

State: **Utah**

Zip:

84116

Phone:

(801) 538-3921 **Ext:** ☐ **TTY**

Fax:

(801) 538-6495

E-mail:

nholmgren@utah.gov

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.

06/24/2020

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: Tonya Hales

State Medicaid Director or Designee

Submission Date: Jun 19, 2020

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

Last Name: Checketts

First Name: Nate

Title: Deputy Director

Agency: Utah Department of Health, Director, Division of Medicaid and Health Financing

Address: 288 N 1460 W

Address 2:

City: Salt Lake City

State: **Utah**

Zip: 84114

Phone: (801) 538-6043 **Ext:** ☐ **TTY**

Fax: (801) 538-6860

E-mail: ncheckets@utah.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

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

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

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

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

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

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

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The State conducted its preliminary categorization by describing services as either “presumed to be compliant” or “requires additional review”. In addition, a listing of provider types and the number of providers has been supplied to help assess the scope of the in-depth reviews that will occur in the upcoming months.

The Department of Health took a conservative approach when designating providers as “presumed to be compliant”. The State only identified services as “presumed to be compliant” when the services are not dependent on the setting and that are direct services provided to the waiver participant. In addition, providers that offer multiple types of services, were categorized as “requires additional review” if the provider had any possibility of providing a service that may not be compliant.

Settings Requiring Additional Review:
Community Based
Adult Day Health Services (7 Providers)
These services may be provided in settings that are not yet compliant. The state has conducted additional evaluations of each provider and setting and is in the process of determining whether the setting is compliant with new regulations, and identify what (if any) remediation steps will be required to bring the setting into compliance.

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.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

The Division of Aging and Adult Services

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).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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 SMA and DAAS sets forth the respective responsibilities for the administration and operation of this waiver. This agreement runs for five year periods, but can be amended as needed.

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

The responsibilities of the operating agency are delegated as follows. Most of the responsibilities are shared with the SMA:

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

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

Appendix A: Waiver Administration and Operation

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

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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:

Eleven Area Agencies on Aging (AAA), through a contract with the Division of Aging and Adult Services (DAAS), perform some Operating Agency functions. The AAAs responsibilities include disseminating information concerning the waiver to potential enrollees through a brochure, assisting individuals in waiver enrollment, managing waiver enrollment as limited by contract, monitoring waiver expenditures as limited by contract, conducting level of care evaluation activities, reviewing participant care plans to ensure that waiver requirements are met, recruiting providers and executing the Medicaid provider agreement.

Appendix A: Waiver Administration and Operation

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:

DAAS monitors and audits each AAA. DAAS also reviews level of care determinations, InterRAI MINIMUM DATA SET – HOME CARE assessments and Care Plans. DAAS also tracks expenditures statewide; signs off on all reasonable and approved administrative expenses incurred by each AAA and checks to make sure all providers are qualified to provide the services they provide.

Appendix A: Waiver Administration and Operation

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:

DAAS monitors and audits each AAA on at least an annual basis. The results of the monitoring and auditing of each AAA are detailed in AAA monitoring and audit reports that DAAS compiles and sends on to the SMA for their review. DAAS also reviews 100% of the level of care determinations, InterRAI MINIMUM DATA SET – HOME CARE assessments and Care Plans for all participants statewide. DAAS also tracks expenditures statewide on at least a monthly basis, signs off on all reasonable and approved administrative expenses incurred by each AAA on a monthly basis and checks all providers initially, when they get their Medicaid number and annually thereafter, to make sure they are qualified to provide services.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the*

function.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percentage of Medicaid provider agreements received and approved by Medicaid prior to the delivery of waiver services. Numerator = Number of agreements

approved by Medicaid prior to the delivery of waiver services; Denominator = Number of total agreements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Approval Documentation and Correspondence

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of Aging Waiver applicants on the waiting list who enter into the waiver according to their numerical ranking. and the date the referral was received. (Numerator = total # of applicants entered into the waiver according to their numerical ranking and the date the referral was received; Denominator = total # of applicants scored and entered into the waiver)

Data Source (Select one):
Other
If 'Other' is selected, specify:
DAAS Application Denial records and Participant records

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every five years	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of applicants denied access to the Aging Waiver following a preliminary level of care screening, who were provided timely notice of appeal rights. (Numerator = total # of applicants denied after screening who were provided appeal rights; Denominator = total # of applicants denied after screening).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Document Approval Forms and DAAS Documents

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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 Aging Waiver program through numerous activities including the issuance of policies, rules and regulations relating to the waiver and the approval of all protocols, documents and trainings that affect any aspect of the Aging Waiver operations. Approvals are accomplished through a formal document approval process. The SMA also conducts quarterly meetings with DAAS (the operating agency), monitors compliance with the Interagency Agreement, receives and reviews executive summary and financial audit reports which profile quality assurances reviews conducted by DAAS on each of the AAAs and provides technical assistance to the operating agency and other entities within the state that affect the operation of the Aging Waiver program. The SMA conducts an annual review of the Aging Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include reviewing a random sample of care plans, Level of Care, MDS-HC assessments and other required documentation from each AAA to be sure all items are compliant with all current policy, rules and regulations. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DAAS and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 80% and a confidence interval equal to 5. The SMA is the entity responsible for official communication with CMS for all issues related to the Aging Waiver.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 DAAS and the SMA that affect the health and welfare of individual participants are addressed immediately. Issues requiring immediate attention are addressed in a variety of ways. Depending on the circumstances of the individual case the interventions could include: contacting the OA, case management and/or direct care provider agencies requiring an immediate review and remediation of the issue, reporting the issue to APS and/or local law enforcement or the state's Medicaid Fraud Control Unit, the licensing authority or the survey/certification authority. To assure the 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. 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.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

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

◉ **No**

○ **Yes**

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

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 one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

- ◉ **Not applicable. There is no maximum age limit**
- ○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

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

- ◉ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

- ○ **A level higher than 100% of the institutional average.**

  Specify the percentage:

- ○ **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:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the 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:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

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	550
Year 2	550
Year 3	550
Year 4	550
Year 5	550

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

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	500
Year 2	500
Year 3	500
Year 4	500
Year 5	500

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

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

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

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

When available capacity and funding exist, individuals that meet the program eligibility requirements, as defined in Appendix B-1, are given a choice to receive services through the Aging Waiver.

If available capacity does not exist, the applicant may access services through a nursing facility, or may wait for available capacity on the Aging Waiver.

DAAS has established a Demographic Intake and Screening (DIS) form by which individuals are ranked to prioritize access to waiver services. The DIS form scores the performance of both ADLs and IADLs and includes a risk assessment to help determine the immediacy of need for services and the individual's risk in not gaining access to waiver services.

Applicants ranked by the DIS form are then placed on a waiting list entitled "The Applicant List" which is maintained by the Operating Agency.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ○ **§1634 State**
- ◉ **SSI Criteria State**
- ○ **209(b) State**

2. Miller Trust State.

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

- ◉ **No**
- ○ **Yes**

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☒ **Optional state supplement recipients**
- ☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ◉ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in**

§1902(a)(10)(A)(ii)(XV) of the Act)

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

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

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

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

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

○ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☐ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

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

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

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

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

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

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

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. 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:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **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 uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). 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-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

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

income:

i. Allowance for the needs of the waiver participant (*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)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

◉ **The following formula is used to determine the needs allowance:**

Specify:

Up to $125 of any earned income and a general disregard of 100% of the FPL for one person; plus shelter cost deduction for mortgage and related costs (property taxes, insurance, etc.) or rent, not to exceed $300; plus the standard utility allowance Utah uses under Section 5(e) of the Food Stamp Act of 1977. Total shelter costs cannot exceed $300 plus the standard utility allowance.

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**
○ **AFDC need standard**
◉ **Medically needy income standard**
○ **The following dollar amount:**

Specify 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:**

Specify:

○ **Other**

Specify:

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 selected.*
- ○ **The state does not establish reasonable limits.**
- ◉ **The state establishes the following reasonable limits**

Specify:

The State establishes the following reasonable limits on post-eligibility income deductions for regular and spousal post eligibility: The limits specified in Utah's Title XIX State Plan for post-eligibility income deductions under 42 CFR Sections 435.725, 435.726, 435.832 and Section 1924 of the Social Security Act. The limits are defined on Supplement 3 to attachment 2.6A.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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**
- ○ **A percentage of the Federal poverty level**

Specify percentage: [ ]

- ○ **The following dollar amount:**

Specify dollar amount: [ ] If this amount changes, this item will be revised

- ◉ **The following formula is used to determine the needs allowance:**

Specify formula:

For individuals with a community spouse: Up to $125 of any earned income and a general disregard of 100% of the FPL for one person; plus shelter cost deduction for mortgage and related costs (property taxes, insurance, etc.) or rent, not to exceed $150; plus one-half of the standard utility allowance Utah uses under Section 5(e) of the Food Stamp Act of 1977. Total shelter costs cannot exceed $150 plus the standard utility allowance.

If the community spouse also participates in an HCBS waiver: Up to $125 of any earned income and a general disregard of 100% of the FPL for one person; plus shelter cost deduction for mortgage and related costs (property taxes, insurance, etc.) or rent, not to exceed $300 (the individual amounts claimed by each spouse may not exceed what they pay in total); a single standard utility allowance may be claimed by either of the spouses, or split between the couple if it may have the effect of reducing their spenddown.

○ **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 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 selected.*

○ **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: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

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

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

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

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

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

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 services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

The local/regional non-governmental non-state entities which consist of eleven AAAs, through contract with DAAS, perform the MDS-HC assessment, level of care determination and reevaluations.

- ○ **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:

Registered Nurse or Physician licensed in the state.

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

Utah State Administrative Rule R414-502 delineates the nursing facility level of care criteria that must be met to qualify for the Medicaid State Plan nursing facility benefit. In accordance with R414-502, it must be determined whether an applicant has mental or physical conditions that require the level of care provided in a nursing facility, or equivalent care provided through a Medicaid Home and Community-Based Waiver program, by documenting at least two of the following factors exist:

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

(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 a Medicaid Home and Community- Based Waiver 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 a Medicaid Home and Community- Based Waiver program.

The use of the MDS-HC in the determination of waiver level of care is equivalent to the use of the MDS in skilled nursing facilities.

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

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The InterRAI MINIMUM DATA SET - HOME CARE (MDS-HC) 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 DAAS staff or their designee, 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 elderly participants in a community setting. The MDS-HC also acts as a screening component that assesses multiple key domains of function, health, social support and service use. Particular MDS-HC items identify participants 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 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 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 level of care evaluation process includes the completion of the MDS-HC assessment and the documentation of the level of care determination on the “Level of Care Determination Form”. The AAA RN is responsible for completing the assessment, and for making the initial level of care determination. They are trained by staff at DAAS or its designee in the proper application of the MDS-HC instrument and the proper analysis of the MDS-HC data to evaluate level of care eligibility. The standard assessment instrument is used for all waiver applicants. DAAS reviews all level of care determinations. The same process is used for reevaluations.

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

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

Specify the other schedule:

The individual's level of care is screened at the time a substantial change in the individual's health status occurs to determine whether the individual continues to meet nursing facility level of care, including at the conclusion of an inpatient stay in a medical institution.

A full level of care reevaluation is conducted whenever indicated by a substantial health status change screening and at a minimum of annually (within the same calendar month as the previous year's assessment).

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform

reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

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 AAA RN is are responsible for the completion of level of care reevaluations have established a “tickler” file process in which a list is generated that shows all the files that are due for reevaluation during a given month.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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.***

Performance Measures

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

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

Performance Measure:
Number and percentage of new participants who are admitted to the waiver for Individuals Age 65 or Older who met nursing facility LOC. (Numerator = # of participants admitted meeting NF LOC; Denominator = total # of participants

admitted)

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC determination Form and MDS-HC

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Annually SMA: At a minimum every 5 years

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

Performance Measures

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

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

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.***

Performance Measures

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

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

Performance Measure:
Number and percentage of participants for whom an assessment for level of care was

conducted by a qualified Registered Nurse or Physician licensed in the state. (Numerator = # of assessments completed by an RN/Physician; Denominator = # of total assessments completed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
MDSHC

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Annually SMA: At a minimum every 5 years

Performance Measure:
Number and percentage of participants for whom Form 927, "Home and Community-Based Waiver Referral Form" documented the effective date of the applicant's Medicaid eligibility determination and the effective date of the applicant's level of care eligibility determination. (Numerator = # of 927 forms documenting the effective date of waiver eligibility; Denominator = total # of 927 forms required)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Records Form 927

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		+/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: At a minimum every 5 years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: At a minimum every 5 years

Performance Measure:
Number and percentage of participants for whom the Level of Care Determination Form accurately documents the LOC criteria based on the MDS-HC assessment. (Numerator = # of LOC forms correctly documenting LOC criteria; Denominator = total # of LOC forms completed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant records, LOC Determination Form and MDS-HC

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5% for SMA
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: OA: 100% Review SMA: Less than 100% Review
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Annually SMA: At a minimum every 5 years

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

All individuals who request Aging Waiver services are pre-assessed by an intake worker at each AAA using the Aging Waiver Demographic Intake and Risk Screening Form. This form is used to determine if an individual is likely to meet nursing facility level of care eligibility. The individuals who are likely to meet nursing facility level of care are placed on an applicant list. Individuals who do not meet the minimum requirements are referred to other programs. Within 30 days of the availability of a slot and funding to accompany it, applicants who meet minimum requirements are evaluated by an R.N. using the Minimum Data Set for Home Care (MDS-HC) tool to determine if the applicant meets nursing facility level of care. Based on the MDS-HC assessment, the level of care criteria is documented on the Level of Care Determination Form.

All initial level of care evaluations and annual re-evaluations are submitted to the DAAS Aging Waiver Program Manager RN or designated DAAS RN for review, eligibility, completeness of information and approval. When insufficient information is submitted to support the level of care determination, the DAAS Program Manager RN or designated DAAS RN will request additional information from the AAA RN, which will result in approval or denial of eligibility. Enrollment in the Aging Waiver program is permitted only after the date the applicant has been determined to meet both eligibility for the Medicaid program and the date nursing facility LOC has been determined. Form 927 “Home and Community-Based Waiver Referral Form” is used to document these dates.

The SMA conducts an annual review of the Aging Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include reviewing a random sample of care plans, Level of Care, MDS-HC assessments and other required documentation from each AAA to be sure all items are compliant with all current policy, rules and regulations. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DAAS and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 80% and a confidence interval equal to 5.

b. Methods for Remediation/Fixing Individual Problems

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

Individual issues identified by the SMA and DAAS that affect the health and welfare of individual participants are addressed immediately. Issues requiring immediate attention are addressed in a variety of ways. Depending on the circumstances of the individual case the interventions could include: contacting the OA, case management and/or direct care provider agencies requiring an immediate review and remediation of the issue, reporting the issue to APS and/or local law enforcement or the state's Medicaid Fraud Control Unit, the licensing authority or the survey/certification authority. To assure the issue has been addressed, entities assigned the responsibility of review and remediations 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.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Annually SMA: Continuously and Ongoing

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.

◉ **No**

○ **Yes**

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: Participant Access and Eligibility

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 between care in a facility and home and community-based waiver service is documented by the appropriate AAA on the form entitled "Documentation of LTC Program Choice and Right to Fair Hearing" which is reviewed with the participant and signed by the participant or their representative. The form is also reviewed by DAAS as part of its annual monitoring and auditing of each AAA. The results of the monitoring and auditing, of each AAA, are detailed in the AAA monitoring and audit reports that DAAS compiles and sends on to the SMA for its review.

Freedom of choice procedures:

1. The AAA, with designated operating agency functions, will offer the choice of waiver services when:
a. The individual's needs assessment indicates the services the individual requires can be met in the community,
b. The care plan has been agreed to by all and
c. The health and welfare of the individual can be adequately protected in relation to the delivery of waiver services and supports.

2. The SMA 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 facility-based care specified for this request, or who are denied waiver service(s) or waiver provider(s).

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

Freedom of Choice forms are found in each participant's file, located at the Area Agency on Aging (AAA) in which they are enrolled as a participant.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency 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 participants are entitled to the same access to an interpreter to assist in making appointments for qualified procedures and during those visits. Providers must notify participants that interpretive services are available at no charge. The SMA encourages participants to use professional services rather than relying on a family member or friend though the final choice is theirs. Using an interpretive service provider ensures confidentiality as well as the quality of language translation.

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

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

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

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *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:*

Service Type	Service
Statutory Service	Adult Day Health
Statutory Service	Case Management
Statutory Service	Homemaker
Statutory Service	Respite and Respite Care Services - LTC Facility
Extended State Plan Service	Enhanced State Plan Supportive Maintenance Home Health Aide Services
Supports for Participant Direction	Financial Management Services
Other Service	Adult Companion Services
Other Service	Chore Services
Other Service	Community Living Services
Other Service	Environmental Accessibility Adaptations
Other Service	Medication Reminder Systems
Other Service	Personal Attendant Services
Other Service	Personal Budget Assistance
Other Service	Personal Emergency Response Systems Installation, Testing, and Removal
Other Service	Personal Emergency Response Systems Purchase, Rental, and Repair
Other Service	Personal Emergency Response Systems Response Center Service
Other Service	Specialized Medical Equipment/Supplies/Assistive Technology
Other Service	Supplemental Meals
Other Service	Transportation Services (Non-Medical)

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult Day Health Services serve the purpose of providing a supervised setting during which health and social services are provided on an intermittent basis to ensure the optimal functioning of the waiver participant.

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

Adult Day Health Services are generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the care plan. Meals provided as part of these services do not constitute a full nutritional regimen (3 meals per day).

Transportation between the individual's place of residence and the adult day care setting will be a separate component and not inclusive in the adult day care rate.

Participants cannot receive Adult Day Health Services and LTC Facility Respite Care Services on the same day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Adult Day Health Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:
Agency
Provider Type:

Medicaid provider enrolled to provide Adult Day Health Services

Provider Qualifications

License *(specify):*

Adult Day Center: UAC R501-13
or
Nursing Facility: UAC R432-150-6
or
Assisted Living Facility: UAC R432-270-29b

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Case Management serves the purpose of maintaining the individual in the Home and Community-Based Services Aging Waiver in accordance with program requirements and the person's assessed service needs, and coordinating the delivery of quality waiver services. Waiver Case Management consists of the following activities:

(a) Validate the comprehensive assessment and the comprehensive care plan for an individual enrolled in the waiver program,
(b) Consult with the agency responsible for waiver eligibility determination;
(c) Research the availability of non-Medicaid resources needed by the individual to address needs identified through the comprehensive assessment process and assist the individual in gaining access to these resources, regardless of the funding source;
(d) Assist the individual to gain access to available Medicaid State Plan services necessary to address needs identified through the comprehensive assessment process;
(e) Assist the individual to select, from available choices on an array of waiver services to address needs identified through the comprehensive assessment process and to select from available choices of providers to deliver each of the waiver services;
(f) Assist the individual to request a fair hearing if choice of waiver services or providers is denied;
(g) Monitor to assure the provision and quality of the services identified in the individual's care plan;
(h) Instruct the individual/legal representative/family how to independently obtain access to services when other funding sources are available;
(i) Monitor on an ongoing basis the individual's health and welfare status and initiating appropriate reviews of service needs and care plans as needed;
(j) Coordinate with other Medicaid programs to achieve a holistic approach to care;
(k) Provide case management and transition planning services up to 90 days immediately prior to the date an individual transitions from a nursing facility to the waiver program;
(l) Provide discharge-planning services to an individual disenrolling from the waiver;
(m) Participate in the person-centered care planning process

When a waiver participant elects to enroll in hospice care, waiver Case Managers shall coordinate with the hospice case management agency upon commencement of hospice services to develop a coordinated plan of care that clearly defines the roles and responsibilities of each program.

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

Direct services not included in the service description above are not reimbursable under case management. (Examples of non-reimbursable services: transporting clients, directly assisting with packing and/or moving, personal budget assistance, shopping, and any other direct service that is not in line with the approved case management service description.)

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide waiver Case Management Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide waiver Case Management Services

Provider Qualifications

License *(specify):*

RN: UCA 58-31b-301
or
SSW: UCA 58-60-205

Certificate *(specify):*

Certification through the National Academy of Certified Care Managers (CMC)

Other Standard *(specify):*

Provider organizations/individuals enrolled to perform the responsibilities of the Waiver Case Management covered service may not provide other direct waiver services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Homemaker Services consist of general household activities (meal preparation, laundry and routine household care) provided by a trained homemaker, when the individual regularly responsible for those activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

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

Homemaker Services will not be provided when the involved activities duplicate activities concurrently being provided through another covered waiver service.

Service Limit: Homemaker Services are limited to six hours or less per week. If more than six hours are required, the Division of Aging and Adult Services will need to authorize the additional hours.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Homemaker Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Homemaker Services

Provider Qualifications

License *(specify):*

Current business license if applicable.

Certificate *(specify):*

Other Standard *(specify):*

Demonstrated ability to perform the tasks.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite and Respite Care Services - LTC Facility

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Respite Care Services consist of care rendered by an attendant, companion, personal care worker, homemaker, home health aide etc., which is provided during the absence of, or to relieve the normal care giver while the covered individual is living in their normal place of residence and that residence is not a long term care facility. Homemaking and Companion can be a component of the respite service. Respite care services are not restricted to the individual's place of residence.

Respite Care Services may be provided in the following locations:

(a) Individual’s home or place of residence
(b) Respite Provider’s place of residence
(c) Other community-based setting meeting HCBS Setting Requirements

LTC Facility Respite Care Services consist of care furnished in a licensed long term care facility during the absence of, or to relieve, the normal caregiver. Each respite care episode is limited to a period of 13 consecutive days or less not counting the day of discharge.

LTC Facility Respite Care Services may be provided in the following locations:

(a) Licensed Health Care Facility
(b) Licensed Residential Treatment Facility

Skilled Respite Care Services consist of care rendered by an attendant, companion, personal care worker, homemaker, home health aide etc., which is provided during the absence of, or to relieve the normal care giver while the covered individual is living in their normal place of residence and that residence is not a long term care facility. Homemaking and Companion can be a component of the respite service. Skilled Respite care services are not restricted to the individual's place of residence.

Skilled Respite Care Services may be provided in the following locations:

(a) Individual’s home or place of residence
(b) Respite Provider’s place of residence
(c) Other community-based setting meeting HCBS Setting Requirements

Skilled respite is used when any of the following needs are provided in conjunction with the respite service:

1. Parenteral lines/enteral tube feeding
2. Wound care/dressing changes
3. Toileting/skilled includes:
    a. Catheters/ostomy/stoma/rectal tubing care
    b. Assisting with enemas and/or suppositories
    c. Assist with bladder and bowel needs or problems for persons with a known infection risk
4. Tracheostomy care
5. Suctioning
6. Care related to IV’s and PICC lines
7. Care related to any equipment or supplies such as ventilators and oxygen equipment
8. Oral feeding for participants at risk of aspiration
9. Medical skin care
10. Medication administration (In compliance with the Utah Nurse Practice Act – within the scope of licensure)

Unskilled respite is used when any of the following needs are provided in conjunction with the respite service:

1. Mobility in bed
2. Transferring
3. Locomotion in and outside the home
    a. Assisting with ambulation including arm support, using a cane, crutches, walker, wheelchair, or other assistive device

4. Dressing
5. Oral Feeding for participants without a risk of aspiration
6. Providing minimal assistance with or supervision of toileting (excludes *skilled toileting cares)
    a. Assist with bladder and bowel needs or problems
    b. Assist with ambulating to the bathroom
    c. Assist with bed pan routines for non-bed bound participants
7. Providing minimal assistance with or supervision of personal Hygiene
    a. Basic nail care for patients with normal nail thickness, normal foot and hand sensation and no history of disease processes that are high risk for foot or hand complications (as outlined in the participant's care plan)
    b. Oral including tooth and denture care
8. Providing minimal assistance with or supervision of bathing (Complete bathing needs to be performed by a home health aide)
    a. Shampoo and hair care
    b. Non-medical skin care (according to the participant's care plan)
    c. Shaving (with electric razor only)
9. Administering emergency first aid
10. Meal preparation, planning and cleanup
11. Ordinary housework
12. Laundry
13. Managing Finances (includes assistance with simple budgeting, paying bills, etc.)
14. Medication reminders and cueing (In compliance with the Utah Nurse Practice Act, Personal Assistants may not administer medications, including the application of prescription ointments or creams)
15. Shopping
16. Transporting the participant

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

The provision of respite care will be provided through the following provider organizations as approved by the State:

(a) Home Health Agency;
(b) Personal Care Agency;
(c) Companion Service;
(d) Homemaker Service;
(e) Adult Day Health Provider.

In a 24 hour period, the hourly respite rate may not exceed the rate paid for daily nursing facility long term care respite.

For LTC Facility Respite Care Services, Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not the person's private residence, or the provider's residence. These state approved facilities are Licensed Health Care Facilities and Licensed Residential Treatment Facilities which include (but are not limited to) the following locations:

(a) Licensed Health Care Facility
(b) Licensed Residential Treatment Facility

Participants cannot receive Adult Day Health Services and LTC Facility Respite Care Services on the same day.

Participants are limited to six LTC respite care episodes per year, additional LTC respite care episodes will need to be approved by DAAS.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Respite Care Services
Agency	Medicaid provider enrolled to provide Respite Care Services - LTC Facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite and Respite Care Services - LTC Facility

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Respite Care Services

Provider Qualifications

License *(specify):*

Home Health Agency: UAC R432-700
or
Adult Day Center: UAC R501-13-1-13
or
Other Organizations: Current business license

Certificate *(specify):*

Other Standard *(specify):*

Demonstrated ability to perform the tasks.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite and Respite Care Services - LTC Facility

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Respite Care Services - LTC Facility

Provider Qualifications

License *(specify):*

Nursing Facility: UAC R432-150
or
Assisted Living Facility: UAC R432-270
or
Residential Treatment Facility: UAC R501-19-13
or
Swing Bed Unit: UAC R432-100-4

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Enhanced State Plan Supportive Maintenance Home Health Aide Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Enhanced State Plan Supportive Maintenance Home Health Aide Services are provided in addition to home health aide services furnished under the approved State plan. These services are provided when home health aide services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from home health aide services furnished under the State plan and are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply. The additional amount of services that may be provided through the waiver is limited to the duration or frequency determined necessary through the comprehensive needs assessment process and delineated in the individual's care plan, but is not otherwise limited by definition in terms of duration or frequency.

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

Supportive maintenance services will only be ordered after full utilization of available State Plan home health services by the individual.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Supportive Maintenance Home Health Aide Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Enhanced State Plan Supportive Maintenance Home Health Aide Services

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Supportive Maintenance Home Health Aide Services

Provider Qualifications

License *(specify):*

Home Health Agency: UAC R432-700

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Financial Management Services are offered in support of the self-directed services delivery option. Services rendered under this definition include those to facilitate the employment of personal attendants or assistants by the individual or designated representative including:
a) Provider qualification verification;
b) Employer-related activities including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports;
c) Medicaid claims processing and reimbursement distribution; and
d) Providing monthly accounting and expense reports to the consumer.

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

Service is provided to those utilizing Self Administered Services.

The monthly payment to the FMS provider can only be made when active financial management services were provided during the month. Payment is not available during inactive periods (such as when there is an interruption in waiver services resulting from an admission to a nursing facility).

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	A provider licensed as a public accounting agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

A provider licensed as a public accounting agency

Provider Qualifications

License *(specify):*

Certified Public Accountant
See 58-26A, UCA and R156-26A, UAC

Certificate *(specify):*

Other Standard *(specify):*

Under State contract with Long Term Care Bureau (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 persons 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-2s. 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 employees 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

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Upon initial enrollment and annual sampling of waiver providers thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Companion Services

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult Companion Services serve the purpose of supporting community activity and preventing social isolation.

Adult companion services involve non-medical care, supervision and socialization. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the individual. The service is provided in accordance with the care plan and is not purely diversionary in nature.

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

Adult Companion Services will not be provided when the involved activities duplicate activities concurrently being provided through another covered waiver service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Adult Companion Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Adult Companion Services

Provider Qualifications

License *(specify):*

Current business license if applicable.

Certificate *(specify):*

Other Standard *(specify):*

Demonstrated ability to perform the tasks.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore Services

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Chore Services include services needed to maintain a clean, sanitary, and safe environment. This service includes any deep cleaning household chores, repair of tile, walls, and flooring, and extermination of rodents and bugs. It may also include snow removal, lawn care or other unforeseen services needed to assist in providing a clean, sanitary and safe environment. These services are provided only when neither the participant nor anyone in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of a rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service.

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

General Limitations: Each chore service exceeding $1,000.00 must be prior approved by the Division of Aging and Adult Services based on a determination of necessity and confirmation that no other payment source is available.

Service Limit: The maximum allowable cost per service is $2,000.00. The $2,000.00 limit applies for each instance/project which has been approved). At the point a waiver participant reaches the service limit, the Division of Aging and Adult Services will conduct an evaluation to determine how the individual's health and welfare can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Chore Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Chore Services

Provider Qualifications

License *(specify):*

Current business license if applicable.

Certificate *(specify):*

Other Standard *(specify):*

Demonstrated ability to perform the tasks.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Living Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Community Living Services include non-recurring expenses which allow for the provision of essential household items and/or services necessary to maintain health and welfare and to establish or maintain community living. Essential household items or services may include basic furnishings, replacement of worn or soiled household items or furnishings, cleaning devices and supplies and kitchen and bathroom equipment. This service includes moving expenses required to occupy and use a residence. This service also includes one-time non-refundable fees to establish utility services and other services essential to the operation of the residence.

Community Living Services will not provide reimbursement for the cost of rent or food. Reimbursable items or services are limited to only those household items that are essential and are not covered under any other service available in the waiver. Reimbursement for the cost of refundable fees or deposits is not a covered expense under this service.

Community Living Services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing. Likewise, Community Living Services may not be used to pay for items that are the responsibility of the landlord or property owner.

This service is a non-recurring set up expense for individuals residing in the community or transitioning from a facility or another provider-operated living arrangement to a living arrangement in a private residence where they are directly responsible for their own living expenses.

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

General Limitations: Each service exceeding $1,000.00 must be prior approved by the Division of Aging and Adult Services based on a determination of necessity and confirmation that no other payment source is available.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Living Supplier of household furnishings, equipment and supplies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living Services

Provider Category:

Agency

Provider Type:

Community Living Supplier of household furnishings, equipment and supplies

Provider Qualifications

License *(specify):*

Current business license if applicable

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

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

Category 4: **Sub-Category 4:**

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

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

Service Definition *(Scope):*

Environmental Accessibility Adaptations involves equipment and/or physical adaptations which are necessary to assure the health, welfare and safety of the individual, or which enable the individual to function with greater independence, and without which, the individual would require facility care. The equipment/adaptations are identified in the individual's care plan and the model and type of equipment are specified by a qualified individual. The adaptations may include purchase, installation, and repairs. Authorized equipment/adaptations include:

(a) Ramps
(b) Grab bars
(c) Widening of doorways/hallways
(d) Modifications of bathroom/kitchen facilities
(e) Modification of electric and plumbing systems which are necessary to accommodate the medical equipment, care and supplies that are necessary for the welfare of the individual.
(f) Modifications or equipment to assist in controlling the temperature of the environment in which the individual resides.

Adaptations which add to the total square footage of a home are excluded from this benefit. Adaptations to living arrangements that are owned or leased by providers of waiver services are also excluded from this benefit. The ownership limitation does not apply if the participant is living in the residence of a family member or friend who is providing self-directed services to the waiver participant. Adaptions to such a residence are permissible. The case management agency will document all funding resources explored and reasons alternative funding is not available. Each environmental accessibility adaptation, which exceeds $2,000.00, must be prior approved by the Division of Aging and Adult Services based on a determination of necessity to assure the health, welfare, and safety of the individual. All services shall be provided in accordance with applicable State or local building codes.

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

Service Limit: The maximum allowable cost per environmental accessibility adaptation is $5,000.00. At the point a waiver participant reaches the service limit, the Division of Aging and Adult Services will conduct an evaluation to determine how the individual’s health and welfare can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual’s needs while remaining in a community setting.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Environmental Accessibility Adaptations

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Environmental Accessibility Adaptations

Provider Qualifications

License *(specify):*

Current business license if applicable and Contractor's License if applicable

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Medication Reminder Systems

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

The Medication Reminder System category covers only the ongoing service fee. Medication reminder system purchase or rental, installation, and testing are elements of the Specialized Medical Equipment/Supplies/Assistive Technology waiver service.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Medication Reminder Systems

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Reminder Systems

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Medication Reminder Systems

Provider Qualifications

License *(specify):*

Current business license if applicable.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Attendant Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Personal Attendant Services include physical and/or cognitive assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may also include assistance with preparation of meals, but does not include the cost of the meals themselves, homemaker services or chore services. It is acceptable to arrange for Personal Attendant Services to be provided during periods when the primary, unpaid caregiver is away. Thus serving a secondary purpose of providing respite, as a self-administered service, to the caregiver. Specific services outlined in the care plan must be coordinated with available State Plan personal care services and other covered waiver services to prevent duplication of services (i.e., having a service provided, such as homemaking through a traditional provider, and then duplicating that service by having a Personal Attendant provide it too). This covered waiver service may be provided via a participant-directed approach or the traditional provider method.

Participant-directed services method: The individual or another duly appointed party, under applicable laws of the State, exercises control over specified staffing decisions relating to his or her personal attendant, including control over the selection and retention of the personal attendant, supervision of the attendant's activities and verification of the personal attendant's time sheet. Providers of Personal Attendant Services may include agency-employed staff when the agency agrees to support the individual's control over specified staffing decisions relating to his or her personal attendant provided by the agency in keeping with the participant-directed services method.

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

Waiver enrollees determined to need the types of services provided by the Personal Attendant Services category will be informed of the opportunity to receive the service through the participant-directed services method. Information will include the option to directly employ the personal attendant or to utilize an agency-employed personal attendant, and the scope and nature of the Fiscal Management Agency that is used when the personal attendant is directly employed.

A case file notation will be made regarding the adequacy of the services provided, any training or retraining necessary, and the continued appropriateness and feasibility of the attendant providing services. The Case Manager will arrange with provider agencies for all training needs of the personal attendants.

In certain cases, an individual may be deemed unable to adequately perform necessary supervisory activities when circumstances render the Personal Representative incapable of performing the supervisory activities that are in the best interest of the participant. In the event it is determined that the individual is unable to adequately perform necessary supervisory activities and has no qualified appointed person to direct the personal attendant, alternative waiver services will be arranged by the local/regional non-state entities utilizing appropriate agencies. Persons having case management involvement with the individual may not serve as surrogates responsible for directing the activities of the personal attendant. Payment will not be made for services furnished by the individual's spouse or other individuals who have a legal responsibility to furnish the services.

Personal Attendant Services are to be a supplement to State plan Personal Care services and the amount, duration, and frequency of Personal Attendant Services must take into account full utilization of State plan personal care services. Medicaid reimbursement is not available for Personal Attendant Services performed for other members of the family. Personal Attendant Services will not be provided when the involved activities duplicate activities concurrently being provided through another covered waiver service. Respite services may not be provided to give respite to the paid provider of Personal Attendant Services. Multiple personal attendants may be hired to assure the needed amount of Personal Attendant Services is provided (i.e., there may be more than one provider that delivers services at different times to the same participant to assure coverage of service).

Fiscal Management Agency: When the personal attendant is employed directly by the participant, the individual is required to use a Fiscal Management Agency to assist with managing the employer-related financial responsibilities associated with the participant-directed model.

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

Service Limit: Personal Attendant Services will not exceed five (5) hours per day. At the point a waiver participant reaches the service limit, the local/regional non-state entities will conduct an evaluation to determine how the individual's health and welfare can continue to be assured through a time-limited authorization for additional service beyond the limit until alternative arrangements are made to meet the individual's needs while remaining in a community setting.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Personal Attendant Services
Individual	Self-directed Personal Attendant Service Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Attendant Services

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Personal Attendant Services

Provider Qualifications

License *(specify):*

Home Health Agency: UAC R432-700 or Personal Care Agency: UAC R432-725

Certificate *(specify):*

Other Standard *(specify):*

Personal attendants will be authorized to provide specific services based on the individuals needs, the personal attendants training and experience, and the degree and type of training and supervision required. In order to qualify as a Medicaid enrolled personal attendant, the applicant must be at least 18 years of age; have the ability to read, understand and carry out written and verbal instructions, write simple progress notes, demonstrate competency in all areas of assigned responsibility on an ongoing basis, provide the designated operating agency with verification of a valid social security number. A copy of a current first aid certification from an accredited agency is required at the time of initial enrollment.

Personal attendants are subject to the requirements of Utah Code Annotated 26-21, 62A-2, and/or 62A-3, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Attendant Services

Provider Category:

Individual

Provider Type:

Self-directed Personal Attendant Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Personal attendants will be authorized to provide specific services based on the individual's needs, the personal attendant's training and experience, and the degree and type of training and supervision required. In order to qualify as a Medicaid enrolled personal attendant, the applicant must be at least 18 years of age; have the ability to read, understand and carry out written and verbal instructions, write simple progress notes, demonstrate competency in all areas of assigned responsibility on an ongoing basis, and provide the designated operating agency with verification of a valid social security number. A copy of a current first aid certification from an accredited agency and/or a copy of a certified nursing assistant certification is required at the time of initial enrollment.

Personal attendants are subject to the requirements of Utah Code Annotated 26-21, 62A-2, and/or 62A-3, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Budget Assistance

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal Budget Assistance provides assistance with financial matters, including fiscal training and assisting the person in their management of financial resources, savings, retirement, earnings and funds monitoring, monthly check writing, bank reconciliation, budget management, tax and fiscal record keeping and filing, and fiscal interaction.

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

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

The Personal Budget Assistance provider must assist the waiver participant in reviewing their finances/budget at least monthly, must maintain documentation of this review and must submit the budget review documentation to the to the Case Management Agency for review on a monthly basis.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide personal budget assistance.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Budget Assistance

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide personal budget assistance.

Provider Qualifications

License *(specify):*

Current business license if applicable

Certificate *(specify):*

Other Standard *(specify):*

Demonstrated ability to perform task.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Upon initial enrollment and routinely scheduled monitoring of waiver providers thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response Systems Installation, Testing, and Removal

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal Emergency Response Systems (PERS) Installation, Testing, and 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:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Personal Emergency Response Systems Installation, Testing, and Removal

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems Installation, Testing, and Removal

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Personal Emergency Response Systems Installation, Testing, and Removal

Provider Qualifications

License *(specify):*

Current business license if applicable.

Certificate *(specify):*

Other Standard *(specify):*

Ability to properly install and test specific equipment being handled.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response Systems Purchase, Rental, and Repair

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal Emergency Response Systems (PERS) Purchase, Rental, and 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.

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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Personal Emergency Response Systems Equipment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems Purchase, Rental, and Repair

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Personal Emergency Response Systems Equipment

Provider Qualifications

License *(specify):*

Current business license if applicable.

Certificate *(specify):*

Other Standard *(specify):*

FCC registration of equipment placed in the individuals home

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response Systems Response Center Service

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal Emergency Response Systems (PERS) Response Center Service serves the purpose of enabling the individual who has the skills to live independently or with minimal support to summon assistance in an emergency.

This 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.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Personal Emergency Response Systems Response Center Service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems Response Center Service

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Personal Emergency Response Systems Response Center Service

Provider Qualifications

License *(specify):*

Current business license if applicable.

Certificate *(specify):*

Other Standard *(specify):*

24 hour per day operation, 7 days per week. The provider must test and record the outcome of the test at least monthly.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment/Supplies/Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized Medical Equipment/Supplies/Assistive Technology includes devices, controls, or other appliances which are of direct medical or remedial benefit to the individual and items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Automated, mechanical medication dispensing, and reminder equipment are included when more simple methods of medication reminders are determined to be ineffective by the designated operating agency nurse. The need for such devices is specified in the individual's care plan. Reimbursement shall include the purchase, installation, removal, replacement, repair and modification of approved equipment, supplies, and adaptations. This service may also be used for the reimbursement of GPS (Global Positioning Systems) devices for an individual who has a documented health and safety risk. The supply and use of these items will only be provided with the approval of the person-centered planning team and with the informed consent of the individual or their legal representative (if applicable).
If there is a documented and assessed need for this GPS surveillance, the requirements for modifications apply:
Specialized Medical Equipment/Supplies/Assistive Technology includes devices, controls, or other appliances which are of direct medical or remedial benefit to the individual and items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Automated, mechanical medication dispensing, and reminder equipment are included when more simple methods of medication reminders are determined to be ineffective by the designated operating agency nurse. The need for such devices is specified in the individual's care plan. Reimbursement shall include the purchase, installation, removal, replacement, repair and modification of approved equipment, supplies, and adaptations. This service may also be used for the reimbursement of GPS (Global Positioning Systems) devices for an individual who has a documented health and safety risk. The supply and use of these items will only be provided with the approval of the person-centered planning team and with the informed consent of the individual or their legal representative (if applicable).
If there is a documented and assessed need for this GPS surveillance, the requirements for modifications apply:

(1) Identify a specific and individualized assessed need.

(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(3) Document less intrusive methods of meeting the need that have been tried but did not work.

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(5) Include regulation collection and review of data to measure the ongoing effectiveness of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the individual or legal representative if the individual does not have the ability to give an informed consent.

(8) Include an assurance that interventions and supports will cause no harm to the individual.

Each item of specialized medical equipment, medical supplies, or assistive technology over $1,000.00, must be prior approved by the Division of Aging and Adult Services based on a determination of medical necessity and confirmation from the Medicaid Agency that the item is not available as a Medicaid State Plan benefit.

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

Service Limit: The maximum allowable cost per item is $2,500.00. At the point a waiver participant reaches the service limit, the Division of Aging and Adult Services will conduct an evaluation to determine how the individual's health and welfare can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Specialized Medical Equipment, Supplies, and/or Assistive Technology

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment/Supplies/Assistive Technology

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Specialized Medical Equipment, Supplies, and/or Assistive Technology

Provider Qualifications

License *(specify):*

Current business license if applicable.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supplemental Meals

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

Elements of Supplemental Meal Category: The Supplemental Meal category includes a home delivered prepared meal, nutritional supplement and/or a community meal. Each option constitutes a supplemental meal when provided in an amount that meets the nutritional needs of the individual.
A community meal may be considered when:
- Participant is socially isolated with few opportunities to access the community; and/or
- Participant continues to experience unintended weight loss despite other meal options provided.

Meals provided as part of this service shall not constitute a "full nutritional regimen" (3 meals per day).

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

The community meal option will be limited to $25.00 per month per participant.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid provider enrolled to provide Supplemental Meal Service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supplemental Meals

Provider Category:

Agency

Provider Type:

Medicaid provider enrolled to provide Supplemental Meal Service

Provider Qualifications

License *(specify):*

Current business license if applicable.

Certificate *(specify):*

Other Standard *(specify):*

Providers that provide supplemental meals that are hot, cold, or frozen and not pre-packaged will need to comply with UAC R70-530. Any provider who provides only "pre-packaged" supplemental meals such as Ensure, Glucerna, etc. will not need to comply with UAC R70-530.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation Services (Non-Medical)

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Non-medical Transportation Services enable individuals served on the waiver to gain access to waiver and other community services, activities, and resources, specified by the care plan. This service is offered in addition to required medical transportation services and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's care plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

The necessary individual transportation service must be stipulated in the care plan with accompanying documentation provided in the case file establishing the need for the transportation to fulfill outcomes associated with another specific service listed in the care plan.

Medicaid payment for transportation under the approved waiver plan is not available for medical transportation, transportation available thru the State plan, transportation that is otherwise available at no charge, or as part of administrative expenditures. Transportation services will be offered to individuals using the most cost effective and efficient method reasonably available within the individual’s community.

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

Non–medical Transportation Services cannot be billed at the same time Personal Attendant Services are billed.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transportation Services (Non-Medical) Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation Services (Non-Medical)

Provider Category:

Agency

Provider Type:

Transportation Services (Non-Medical) Provider

Provider Qualifications

License *(specify):*

Licensed public transportation carrier
or
Individual driver's license
or
Current business license if applicable

Certificate *(specify):*

Other Standard *(specify):*

Registered and insured vehicle: UCA 53-3-202, UCA 41-12a-301

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver

participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **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 requires that all persons having direct access to vulnerable adults, as a personal attendant, must undergo a criminal history/background investigation and fingerprinting.

The Office of Licensing, an agency within the Utah Department of Human Services, has the responsibility of conducting background checks on all personal attendants who provide waiver Personal Attendant Services. The scope of the investigation includes checking state, regional and national criminal background databases, searching the Department of Human Services, Division of Child and Family Services' Licensing Information System, searching the Department of Human Services, Division of Aging and Adult Services' vulnerable adult abuse, neglect, or exploitation database, searching the juvenile court records for substantiated findings of severe child abuse or neglect and searching the juvenile court arrest, adjudication and disposition records.

No personal attendant will be paid for services rendered until the background investigation is completed and they have received an approved background screening application. Each AAA must submit a background screening annually on each personal attendant providing Personal Attendant Services in their catchment area. The annual renewal should be submitted. to the Utah Department of Human Services, Office of Licensing no later than one year from the date of their most recent background screening approval. A screening that has lapsed for 30 days beyond that time is void and a new initial application must be submitted.

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):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **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 requires that all persons having direct access to vulnerable adults, as a personal attendant, must undergo an abuse register screening as part of the criminal background investigation.

A designated staff person within DHS, Office of Licensing, completes all screenings. The screening(s), for those receiving Personal Attendant Services, are maintained in the participant file at the AAA in which they are enrolled.

DAAS ensures that mandatory screenings have been conducted during its annual audit for those individuals who have Personal Attendants.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

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

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ○ **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).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

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

- ◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar*

services for which payment may be made to legally responsible individuals under the state policies specified here.

☐ **Self-directed**

☐ **Agency-operated**

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

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

As per Administrative Rule R539-5-5 Legal guardians and spouses are not permitted to provide waiver services. Relatives, other than those listed above, may provide specified waiver services. The same payment controls are employed as described in Appendix I-1:1.
Additionally, to ensure that employed relatives receive payments only for services rendered, the AAAs conduct monthly reviews of all services provided and claims paid. Case Managers monitor the quality and delivery of services as defined in the care plan. As the AAAs conduct monthly reviews, if there is any indication of fraud or abuse of funds, DAAS is immediately notified so more in-depth audits can be completed.

○ **Other policy.**

Specify:

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

All potential providers can access the State Implementation Plan of the Aging Waiver on the internet to see what qualifications they must have to provide a service. They can file for a Medicaid number at any time by applying online with Utah Medicaid through the PRISM system. DAAS and the Utah Department of Health reviews the requested services and licenses and/or certifications. When the provider is approved for the Aging Waiver, the AAAs are notified by DAAS that a new provider is approved and ready to provide services. The AAAs will add the provider to the Freedom of Choice of Providers Form and the participant then chooses their providers from the Freedom of Choice of Providers Form that is maintained by the AAA.

The Utah Department of Health will enter into a provider agreement with all willing providers who are selected by participants and meet licensure, certification, competency requirements and all other provider qualifications. These providers must agree to accept the Medicaid rate as payment in full.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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.***

Performance Measures

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

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

Performance Measure:
Number and percentage of licensed health care providers who meet required licensing standards both at initial enrollment and ongoing. (Numerator = # of providers in compliance; Denominator = total # of providers reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Bureau of Licensing Records Office of Licensing Records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DOH Bureau of Licensing DHS Office of Licensing	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: At a minimum of every 2 years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DOH Bureau of Licensing DHS Office of Licensing	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

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

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

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

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

Performance Measure:
Number and percentage of personal attendants who received an approved background screening prior to providing services and whom an annual screening was completed annually thereafter.(Numerator=total # of PAs who received an approved background screening prior to providing services and whom an annual background screening was completed. Denominator=total # of PAs employed who received annual review)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Approved Background Screening application and Participant records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years.	

Data Aggregation and Analysis:

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

c. ***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 the State will use to assess compliance with the statutory assurance,

complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percentage of new Registered Nurses who received MDS-HC/LOC training prior to accessing participants for the Aging Waiver program. (Numerator = # of RNs in compliance; Denominator = total # of RNs reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider training agenda

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

The SMA conducts an annual review of the Aging Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include reviewing a random sample of care plans, Level of Care, MDS-HC assessments and other required documentation from each AAA to be sure all items are compliant with all current policy, rules and regulations. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DAAS and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 80% and a confidence interval equal to 5.

b. Methods for Remediation/Fixing Individual Problems

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

Individual issues identified by the SMA and DAAS that affect the health and welfare of individual participants are addressed immediately. Issues requiring immediate attention are addressed in a variety of ways. Depending on the circumstances of the individual case the interventions could include: contacting the OA, case management and/or direct care provider agencies requiring an immediate review and remediation of the issue, reporting the issue to APS and/or local law enforcement or the state's Medicaid Fraud Control Unit, the licensing authority or the survey/certification authority. To assure the issue has been addressed, entities assigned the responsibility of review and remediation is 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.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Annually SMA: At a minimum every five years

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

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

Settings Compliance process: During enrollment, the provider submits a New Provider Settings Attestation Form and a Settings Self-Assessment for each setting. The SMA and OA will conduct a review of the information provided and identify any conflicts with the Settings Rule.

The Attestation form, the Self-Assessment, and the providers policy and procedure documents will be reviewed as part of this process. The SMA and OA will interview the provider's leadership and make an initial determination of settings compliance. State staff will work with the provider to address any areas that require remediation prior to providing services. Once initial compliance is determined, the provider can start services in the setting and validation of compliance which may include participant and staff interviews, site visits, reviews conducted by Case Managers, etc.

Maintain Ongoing Compliance: Once overall compliance is achieved, strategies to ensure ongoing compliance for all providers will include conducting periodic participant experience surveys, building questions from the Settings Rule into annual service planning process, settings policy guidance as defined by provider manuals and state implementation plans, and ongoing provider certification that they have received information about and understand the settings requirements. Utah's existing quality assurance system will also include ongoing HCBS setting compliance monitoring; this includes ongoing critical incident report monitoring, case manager monitoring, licensing monitoring and HCBS Waiver reviews.

Provider owned/operated settings where individuals will reside or receive services: Adult Day Health Services; LTC Respite.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Care Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☒ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

- ☐ **Social Worker**
  Specify qualifications:

- ☐ **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Case Management Agencies are prohibited from performing other direct care waiver services other than in instances where a willing and qualified provider is not enrolled, or does not have the capacity to serve the individual.

All instances of CMA direct service provision are authorized by the OA and are reviewed to ensure other providers are not available prior to their delivery, which may include verifying information with the participant or their authorized representative. During provider enrollment, the State verifies the counties/service areas which providers are able to perform service in. The State uses this information to create its "Freedom of Choice" forms which are provided to the individual during care plan development. These forms also supply the full list of waiver services and enrolled providers based on geographic area. Evidence to support insufficient providers would be required prior to the OA authorizing the CMA to perform the service on the care plan.

Direct oversight of this process is maintained by the OA through the person-centered care planning process. All care plans (including amendments) listing the Case Manager as the rendering provider of other direct care services requires approval by the OA. During this process, an evaluation would occur to confirm the AAA/Case Manager was the only willing/qualified provider. During enrollment activities, the SMA and OA capture information to verify the areas/counties of the state the the provider will be serving. This information is used to confirm that an enrolled provider is not available, or used to validate that existing providers do not have capacity or are unwilling to serve the individual. (The State only allows for direct services to be performed by the AAA/Case Manager due to access to care issues). It is also during this evaluation that the SMA/OA confirm the process by which the CMA will separate its Case Management and Direct Service functions. This may be demonstrated through the use of separate legal business entities, the agency's organizational structure, etc.

Waiver participants may appeal if their choice of service provider is denied. The SMA/OA would determine if the individual's selection of provider was due to the inability of the provider to render service or if the CMA was inappropriately influencing choice. This may result in corrective action against the CMA.

Provider entities having the capacity to perform case management functions and other waiver or non-waiver services must assure that the functions of the entity are clearly separated and their respective responsibilities well defined. If the AAA or case management agency is listed on a comprehensive care plan as the provider for other waiver or non-waiver services, the case management agency must document that there are no other willing qualified providers available to provide the other waiver or non-waiver service(s). This includes instances where the AAA or case management agency pays for goods and services purchased from retail stores, general contractors or other entities not directly enrolled as Medicaid providers.

Case management agencies may not assign individual case managers to serve a waiver participant when any one or more of the following scenarios exist:

1. the case manager is related to the waiver participant by blood or by marriage,
2. the case manager is related to any of the waiver participant’s paid caregivers by blood or by marriage,
3. the case manager is financially responsible for the waiver participant,
4. the case manager is empowered to make financial or health-related decisions on behalf of the individual, or
5. the case manager would benefit financially from the provision of direct care services included in the care plan.

The State has implemented the use of a Financial Management Service (FMS) entity to pay for goods and services purchased from retail stores, general contractors or other entities not directly enrolled as Medicaid providers. The State reimburses the FMS entity as an administrative activity.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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.

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.
The Home and Community Based Waiver for Individuals Age 65 and Older brochure is provided to the participant, and/or family member(s) or legal representative, when the participant is new to the Aging Waiver program. This brochure lists the Aging Waiver services that are available under the waiver.

b) The participant's authority to determine who is included in the process.
The participant has total authority to determine who is included in the process. The nurse completing the assessment explains this authority to the participant and it is documented on the care plan by the participant's signature.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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):

a) Who develops the plan, who participates in the process, and the timing of the plan.
There are 11 AAAs across the state that have designated operating agency functions. The care plan is developed by the area AAA where the participant lives. Specifically, the RN or the RN and the Case Manager from the AAA develops the plan with input from the participant, and where applicable, the participant's family and friends. Within 30 calendar days after the full assessment (whether a new assessment or reassessment) a care plan must be developed. For care plans undergoing an annual review, the care plan must be developed within the same calendar month as the previous year's care plan. Care planning meetings are scheduled with the individual, and/or their representative in their home, or location of their choosing and at times available to all parties.

b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences, strengths, capacities, desired outcomes, goals, risk factors and health status.
The InterRAI Minimum Data Set- Home Care (MDS-HC) and supplement are the tools used to assess the participant. Information about the participant is gathered from the participant, their family or friends and their physician when warranted.

c) How the participant is informed of the services that are available under the waiver.
The participant is given a brochure, which explains the program and also lists all available services offered. When the Case Manager meets with the participant, after the care plan is develooped and agreed upon,the participant is given a Freedom of Choice of Providers Form listing all available providers for all services in the catchment area.

d) How the plan development process ensures that the care plan addresses participant goals, needs (including health care needs), and preferences.
Care Plan development is based on the health and other needs identified in the comprehensive assessment. Services are identified on the care plan and are reviewed at a minimum, quarterly. This is to assure that services continue to meet the participant's needs and that they are satisfied with their choice of providers and services. Care plans are revised when required to address changes in the individual's needs. Care plan changes are handled in a similar fashion to initial and annual planning meetings.

e) How waiver and other services are coordinated.
As part of the care plan development, it is the responsibility of the CM to link the participant with the services identified on the care plan. The Case Manager identifies all resources available to meet these needs, both formal and informal. The Case Manager must also document other resources they attempted to implement, and why these attempts failed and were unavailable before using Aging Waiver funds to pay for the service.

f) How the plan development process provides for the assignment of responsibilities to implement and monitor a care plan.
The Case Managers will make a monthly contact, either by phone or in person, to monitor the delivery and quality of services provided as well as identify any significant changes in the participant's health and welfare or their circumstances. At a minimum, a quarterly face-to-face visit is required. The quarterly review includes a review of the care plan, health status, mobility, self-care, mental health status and social status of the waiver participants. Additionally, the condition of any medical equipment in the home is evaluated. For those receiving participant-employed Personal Attendant Services, the quarterly review also documents that the back-up plan remains in effect.

g) How and when the plan is updated, including when the participant's needs change.
The care plan is updated at a minimum of annually. The care plan must be developed within the same calendar month as the previous year's care plan. The MDS-HC is administered and a new care plan is developed based on this assessment. If a significant change in the participant's condition occurs at any time prior to the annual review, the Case Manager must notify the R.N. to screen the level of care to determine if it adequately reflects the participant's condition or if a new MDS-HC needs to be conducted to determine ongoing nursing facility level of care and to determine that all identified needs are and can be met. The care plan is updated, when warranted, by changes in the waiver participant's needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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 InterRAI Minimum Data Set- Home Care (MDS-HC) is the screening tool used by the R.N. to assess and document multiple key domains of function, health, social support and service use. It focuses on social functioning, environmental issues, physical functioning, health conditions, service utilization, medications, informal support services, cognitive patterns, communication/hearing patterns, vision patterns, mood and behavior patterns, continence issues, disease diagnoses, nutrition/hydration status, dental status and skin conditions. This information identifies the potential risks facing the participant.
Formal and/or informal services are then added and documented on the care plan.

If a participant chooses the self-directed model for service delivery, at least one but up to three people or a traditional service provider are identified to provide back-up services when the Personal Attendant is unavailable. The backup plan will be reviewed quarterly.

The back-up plan primarily addresses when scheduled self-administered waiver supports are interrupted, usually due to an employee who is unable to complete a given day's services, to ensure the individual's health and safety needs can be met.

The MDS-HC may help develop alternative strategies to mitigate risk should there be a delay in finding a substitute caregiver, or if there is a delay in someone being able to assist the individual. (ex. Usage of DME for mobility; transferring/repositioning strategies; etc.)

Agencies are expected to develop protocols in order to meet scheduled appointments with participants.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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.

State Response: During care planning meetings, the individual is presented with the names and contact information of all agencies providing service(s) in their geographic area. They are encouraged, and assisted when necessary, in contacting the agencies to find the provider which best meets their needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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

The SMA retains final authority for oversight and approval of the care planning process. The oversight function involves, at a minimum, an annual review of a representative sample of waiver enrollee's care plans that will be sufficient to provide a confidence level equal to 80% and a confidence interval equal to 5. The specific sample 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 care planning problems, an expanded review is initiated by the SMA.

In order to ensure adequate representation of all enrolled Case Management Agencies, the SMA and OA work to stratify the sample of random participants reviewed. The State may also conduct targeted reviews of certain providers/individuals if concerns have been noted in their care delivery.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

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

- (●) **Every three months or more frequently when necessary**
- ( ) **Every six months or more frequently when necessary**
- ( ) **Every twelve months or more frequently when necessary**
- ( ) **Other schedule**

Specify the other schedule:

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

- [ ] **Medicaid agency**
- [ ] **Operating agency**
- [x] **Case manager**
- [x] **Other**

Specify:

The AAA in which the participant resides.

Appendix D: Participant-Centered Planning and Service Delivery

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.

a) The entity (entities) responsible for monitoring the implementation of the care plan and participant health and welfare.

The Case Manager is responsible for monitoring the implementation of the care plan and the participant's health and welfare. During the care planning process it is the responsibility of the Case Manager and the RN at the AAA to monitor for non-compliant HCBS settings as well as to document any human rights restrictions which apply to the participant. This documentation must include information on the restriction, why it is being used, what lesser intrusive methods were tried previously (and why they were insufficient to maintain the health and safety of the individual) and a plan to phase-out the use of the intervention/restriction (if possible).

b) The monitoring and follow-up method(s) that are used.
During contacts with participants, Case Managers (CM) ask the participant about the delivery and quality of the services they are receiving. CMs also observe the services being delivered when possible and have contact with the providers. CMs work directly with providers if participants identify problems and ask for the CM to intervene. This is completed as soon as the problem is identified. The AAA will notify DAAS if there are more global concerns with a particular provider and DAAS then notifies the SMA. These types of issues with providers are also detailed in the AAA monitoring and audit reports that DAAS compiles and sends on to the SMA for its review.

Additionally, it is the responsibility of the CM to ensure participants have access to all waiver services identified on the care plan. If there are non-waiver services that the participant needs, the CM will help the participant to obtain access to those services as well. While it is the responsibility of the CM to verify the quality and delivery of services, the AAAs validate the financial component of the care plan. This is substantiated by having the AAAs compare their billings against the care plans of their participants.

c) The frequency with which monitoring is performed.
At a minimum, a monthly contact is made, via phone or in person, by the CM and a more comprehensive, face-to-face visit is completed on at least a quarterly basis. During the quarterly review, the CM verifies back-up plans for Personal Attendant Services (PAS) are effective and that the participant's health and welfare is assured. Moreover, DAAS checks the APS database at least twice a year, and if notified, follows the investigation by APS as it unfolds.

If the participant has left the state for more than 90 days and is therefore unable to meet the quarterly face-to face monitoring requirement, the participant may be disenrolled from the waiver.

Furthermore, to confirm that participants exercise free choice of providers, they must choose their providers at a minimum of yearly. As previously stated, CMs may work to resolve issues between the participant and the provider, at the participant's discretion, and may also help the participant to obtain a different provider if they are unhappy with the services offered by their current provider.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

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

i. Sub-Assurances:

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.***

Performance Measures

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

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

Performance Measure:
Number and percentage of care plans which address all needs, personal goals and health and safety factors that are identified in the full assessment. (Numerator = # of care plans addressing all needs identified; Denominator = total # of care plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
MDS-HC Assessment and Supplement Nutritional Risk Screening Form Care Plans

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every five years	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of care plans which are reviewed at a minimum quarterly to assure they continue to meet the participant's needs. (Numerator = # of care plans where all quarterly assessments were completed; Denominator = total # of care plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan, Medicaid waiver for Individuals Age 65 or Older Quarterly review and Participant Record

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every five years	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of participants using the self-directed model for service delivery in a representative sample for which the Personal Attendant Service Emergency Back-up Form was completed and current. (Numerator = # of participants receiving PA SAS services with a back-up plan developed; Denominator = total # of participants receiving PA SAS services)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and ongoing SMA: At a minimum of every 5 years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Continuously and ongoing SMA: At a minimum of every 5 years

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

Performance Measures

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

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

Performance Measure:
Number and percentage of care plans that are updated when warranted by changes in the waiver participant's needs. (Numerator = # of care plans updated due to a change in a participant's needs; Denominator = # of care plans requiring update due to a change in the participant's needs)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant records and Care Plan

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every five years	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of care plans that are updated, at a minimum of annually (within the same calendar month as the previous care plan). (Numerator = # of care plans updated within required timeframes; Denominator = total # of care plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan, Participant record and MDS-HC with supplements

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Annually SMA: At a minimum every five years

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.***

Performance Measures

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

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

Performance Measure:
Number and percentage of care plans that identify the amount, frequency, duration, type, and scope for each waiver service. (Numerator = # of care plans where amount/frequency/duration/type/scope for all waiver services was provided; Denominator = # of care plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant records and Care Plan

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		+/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every five years	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of participants whose record contains documentation they were contacted by their Case Managers, monthly, either by phone or in person to monitor the delivery and quality of services. (Numerator = # of participants where monthly contacts where completed; Denominator = total # of participants reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plans and Claims data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every five years	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percentage of participants who were offered the choice between institutional care and home and community based waiver services as documented on the "Documentation of LTC Program Choice and Right to Fair Hearing" form. (Numerator = # of participants where choice of service delivery was documented; Denominator = total # of participants reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Documentation of LTC Program Choice and Right to Fair Hearing form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Annually SMA: At a minimum every five years

Performance Measure:
Number and percentage of participants who were given a list of all services/service providers in the catchment area, annually. (Numerator = # of individuals given a list of all service providers in the waiver year; Denominator = # of participants enrolled for the full waiver year)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Choice Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every five years	

Data Aggregation and Analysis:

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

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 DAAS Program Manager Rn or designated DAAS RN for the Aging Waiver reviews 100% of care plans prior to their becoming effective to assure that all assessed needs are addressed on the care plan, regardless of funding source, and that each care plan meets all requirements including amount, frequency and duration of services. DAAS conducts annual audit of each of the AAA's. Documents are reviewed either on site or at the DAAS office. During on site reviews, DAAS reviews records and visits participants to assure that care plans are sufficient to meet participant needs, services are being delivered and participants are satisfied with their providers. The sample size for each review will be sufficient to provide a confidence level equal to 80% and a confidence interval equal to 5.

The SMA conducts an annual review of the Aging Waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include reviewing a random sample of care plans, Level of Care, MDS-HC assessments and other required documentation from each AAA to be sure all items are compliant with all current policy, rules and regulations. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DAAS and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 80% and a confidence interval equal to 5.

b. Methods for Remediation/Fixing Individual Problems

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

Individual issues identified by the SMA and DAAS that affect the health and welfare of individual participants are addressed immediately. Issues requiring immediate attention are addressed in a variety of ways. Depending on the circumstances of the individual case the interventions could include: contacting the OA, case management and/or direct care provider agencies requiring an immediate review and remediation of the issue, reporting the issue to APS and/or local law enforcement or the state's Medicaid Fraud Control Unit, the licensing authority or the survey/certification authority. To assure the issue has been addressed, entities assigned the responsibility of review and remediations 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.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	OA: Continuously and Ongoing SMA: At a minimum of every five years

c. Timelines

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

- (●) **No**
- ( ) **Yes**

  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

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

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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.

a) The nature of the opportunities afforded to participants.
The Personal Attendant Service is the only waiver service that offers an opportunity for participant direction. This service may be provided as either a self-directed service or an agency based service.

b) How participants may take advantage of these opportunities.
When the Personal Attendant Service is provided as a self-directed service, individuals and/or their chosen representative hire individual employees to perform this waiver service. The individual and/or their chosen representative are then responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheets, etc.

c) The entities that support individuals who direct their services and the supports that they provide.
When the Personal Attendant is employed directly by the participant and/or their chosen representative, the use of a Financial Management Agency is required. The Financial Management Agency assists with managing the employer related financial responsibilities associated with the participant directed model.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☒ **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

  Participant direction opportunities are available to participants who live in the home of a friend.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

a) 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 participants representative) to inform decision-making concerning the election of participant direction.

The participant or their personal representative signs a Consumer Letter of Agreement form, Emergency Back-Up form and, if a representative is designated, a Designation of Personal Representative Agreement form. The Consumer Letter of Agreement form defines the responsibilities of the participant including hiring, training and supervising their employees, how to terminate employees, verification of employee hours submitted on time sheets to the financial management services provider, what to do if they need additional training to be an employer, what is required of their employees, what to do if there is a conflict or non-compliance with an employee, reasons for potential discontinuation of the service and the right to appeal a decision for discontinuation. The Emergency Back-up form lists up to three individuals or a traditional service provider if there are not other individuals who are willing or able to provide services that could provide services if the regular attendant was not available. The Designation of Personal Representative Agreement form identifies who the personal representative is and their responsibilities to the participant and their employee(s).

b) The entity or entities responsible for furnishing this information.
It is the responsibility of the Case Manager to furnish the information.

c) How and when this information is provided on a timely basis.
If it is determined during the assessment, by the AAA, that the participant desires to self direct their services and has the capacity to do so, or has a responsible representative to do so, then the participant and/or their representative are presented information by the Case Manager (CM).

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

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:

The representative signs a Designation of Personal Representative Agreement form which describes the representative's role and responsibilities. This form explains that the representative must follow Medicaid waiver rules, regulations and procedures. Individuals designated as personal representatives are prohibited from providing any waiver services. Compliance reviews are conducted by the case management agency.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Personal Attendant Services	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services

○ **FMS are provided as an administrative activity.**

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:

Payment for FMS is a monthly unit that is paid to the providers.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

In support of self-administration, Financial Management Services will assist individuals in the following activities:

1. Verify that the employee completed the following forms
   a. Form I-9, including supporting documentation (i.e. copies of driver's license, social security card, passport). If fines are levied against the person for failure to report INS information, the FMS shall be responsible for all such fines.
   b. Form W-4
2. Obtain a completed and signed Form 2678, Employer Appointment of Agent, from each person receiving services from the Financial Management Services provider, in accordance with IRS Revenue Procedure 70-6.
3. Provide persons with a packet of all required forms when using a Financial Management Services provider, including all tax forms (IRS Forms I-9, W-4 and 2678), payroll schedule, Financial Management Services provider's contact information, and training material for the web-based timesheet.
4. Process and pay approved employee timesheets, including generating and issuing paychecks to employees hired by the person.
5. Assume all fiscal responsibilities for withholding and depositing FICA and SUTA/FUTA payments on behalf of the person. Any federal and/or State penalties assessed for failure to withhold the correct amount and/or timely filing and depositing will be paid by the Financial Management Services provider.
6. Maintain a customer service system for persons and employees who may have billing questions or require assistance in using the web-based timesheet. The Financial Management Services provider will maintain an 800-number for calls received outside the immediate office area. Messages must be returned within 24 hours Monday thru Friday. Messages left between noon on Friday and Sunday evening shall be returned the following Monday.
   a. Must have capabilities in providing assistance in English and Spanish. The FMS must also communicate through TTY, as needed, for persons with a variety of disabilities.
7. File consolidated payroll reports for multiple employers. The Financial Management Services provider must obtain federal designation as Financial Management Services provider under IRS Rule 3504, (Acts to be Performed by Agents). A Financial Management Services provider applicant must make an election with the appropriate IRS Service Center via Form 2678, (Employer Appointment of Agent). The Financial Management Services provider must carefully consider if they want to avail the Employers of the various tax relief provisions related to domestics and family employers. The Financial Management Services provider may forego such benefits to maintain standardization. Treatment on a case-by-case basis is tedious, and would require retroactive applications and amended employment returns. The Financial Management Services provider will, if required, comply with IRS Regulations 3306(a)(3)(c)(2), 3506 and 31.3306(c)(5)-1 and 31.3506 (all parts), together with IRS Publication 926, Household Employer's Tax Guide. In order to be fully operational, the Form 2678 election should be postured to fall under two vintages yet fully relevant Revenue Procedures; Rev. Proc. 70-6 allows the Financial Management Services provider file one employment tax return, regardless of the number of employers they acquire.

Supports furnished when the participant exercises budget authority:

- ☐ **Maintain a separate account for each participant's participant-directed budget**
- ☐ **Track and report participant funds, disbursements and the balance of participant funds**
- ☐ **Process and pay invoices for goods and services approved in the service plan**
- ☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The SMA and the OA will assure that high standards are maintained by utilizing the following: surveys of participants, regular observation and evaluation by Case Managers, provider quality assurance reviews, and other oversight activities as appropriate.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

During the comprehensive needs assessment process, the OA R.N. will identify each individual's needs that can be addressed through any available self-directed waiver services. The case management agency will inform the individual or a representative of the opportunity to utilize self-direction for their identified services and discuss the options for personal choice in directly employing a chosen person or to utilize an agency-based provider for services.

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Adult Day Health	☐
Chore Services	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supplemental Meals	☐
Personal Emergency Response Systems Response Center Service	☐
Homemaker	☐
Financial Management Services	☐
Personal Emergency Response Systems Installation, Testing, and Removal	☐
Enhanced State Plan Supportive Maintenance Home Health Aide Services	☐
Transportation Services (Non-Medical)	☐
Adult Companion Services	☐
Personal Emergency Response Systems Purchase, Rental, and Repair	☐
Personal Attendant Services	☐
Respite and Respite Care Services - LTC Facility	☐
Personal Budget Assistance	☐
Environmental Accessibility Adaptations	☐
Specialized Medical Equipment/Supplies/Assistive Technology	☐
Medication Reminder Systems	☐
Case Management	☐
Community Living Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **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:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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 participant or their personal representative notifies the Case Manager (CM) that they no longer wish to participate in self-directed services. The CM then meets with the participant and/or their personal representative to revise the care plan and select a provider from the Freedom of Choice of Providers Form. The CM then contacts these providers and issues a service authorization to them.

There would not be a delay in services as the participant has already chosen what to do if their back- up plan fails. Traditional providers are listed in place of their personal attendant or back-up personal attendant(s).

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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.

Potential suspension or discontinuation of personal attendant services could include the following:
- Hospitalization or short term placement in a nursing or rehabilitation facility
- Change in condition of the participants ability to manage the services and if there is no personal representative available.
- Failure to provide required agreements or comply with requirements.
- Evidence that services are not being performed or the employee(s) is providing services outside of service specifications.
- Report of a participant being abused or exploited by the employee or personal representative.
- Participant or their representative fails to cooperate with authorization changes or rules.
- Evidence that hours were billed for services that were not provided.

The Personal Attendant Service Consumer Letter of Agreement form, which is signed by the participant and/or their representative, informs the participant, in advance, of the circumstances that may result in involuntary termination of participant direction. Also, prior to discontinuing services provided by the personal attendant, the case manager (CM) will confer with the operating agency (OA) regarding the reason(s) for the discontinuation. If the OA agrees to discontinue the services provided by the personal attendant, then the CM will be instructed to discuss the reason(s) for discontinuing the service with the participant and/or their personal representative and assist them in obtaining needed services through a different provider(s).

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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	55	
Year 2	55	
Year 3	55	
Year 4	55	
Year 5	55	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

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

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

☐ **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:

☒ **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. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

It is the responsibility of the AAAs to obtain an annual background screening on each participant’s Personal Attendant Services (PAS) employee(s). The PAS provider must pay for their own background screening and fingerprinting as a requirement for employment.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

It does not vary from C-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

☐ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☐ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☐ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **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:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

When the participant begins receiving Aging Waiver services, they must sign a Right to Fair Hearing form provided to them by the OA. This document informs the participant, and/or their representative, of their right to appeal an alleged adverse action in regard to their participation in the waiver program. The Right to Fair Hearing document elaborates on the time frame to file an appeal and lists how an appeal may be requested.

The OA also sends the participant a Notice of Decision (NOD) form anytime an action could negatively impact them including: not allowing choice between care in a skilled nursing facility instead of HCB services; denying an individual's choice of services and/or providers of those services; or actions to deny/suspend/reduce or terminate services. The purpose of the NOD form is to inform the participant of the adverse action, their right to a fair hearing and continued service during the hearing process, the time frame to file an appeal and who to contact to file an appeal.

The participant is encouraged to utilize an informal dispute resolution process with the AAA to expedite equitable solutions, but may forgo or interrupt the available informal resolution process at any time by completing a request for a formal hearing. The participant can request a formal hearing by completing a Request for Hearing/Agency Action form and submitting it to the Department of Health, Division of Medicaid Health Financing within 30 days.

Appendix F: Participant-Rights

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:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

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).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

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

State of Utah Reporting Requirements:

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

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

The SMA requires that the DAAS administration report critical incidents/events, by e-mail, phone or in person, within 24 hours or on the first business day after the event occurs. Reportable incidents or events include: any unexpected or accidental deaths, all suicide attempts, medication errors that result in the participant experiencing adverse side effects requiring medical treatment at a medical clinic or emergency room or admission to a hospital, or unexpected, hospitalization or other serious outcomes, provider or caregiver abuse or neglect, including self-neglect that results in medical treatment at a medical clinic or emergency room or hospitalization, accidents that result in hospitalization, missing, human rights violations such as unauthorized use of restraints, criminal activities involving law enforcement that are perpetrated by or on a waiver participant, events that compromise the participant's working or living environment that put a participant(s) at risk, Medicaid fraud that involves alleged or confirmed waste, fraud or abuse of Medicaid funds by either a provider or a recipient of Medicaid services. In addition, events that are anticipated to receive media, legislative, or other public scrutiny are required to be reported to the SMA immediately.

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

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

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

The Case Manager provides information to the participant, regarding potential situations that should be reported to Adult Protective Services and/or their Case Manager, initially upon enrollment and annually thereafter. The CM will begin documenting this on the Freedom of Choice of Providers Form upon approval of the waiver. They also inform the participant about self-neglect and that this is a mandatory reporting incident. They are given the CMs phone number as well as APS phone number.

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

Responsibility of the State Medicaid Agency
After a critical incident/event is reported to the SMA by the OA, the OA investigates the incident/event and submits the completed Critical Incident/Event Investigation to the SMA within ten business days of reporting the incident/event. Within ten business days after receiving the critical incident investigation from, the SMA will review the investigation form submitted by the OA. Cases that are complicated and involve considerable investigation may require additional time to complete the findings document. The OA may request additional time by contacting SMA staff with a proposed due date. A new negotiated date is agreed to by the SMA and OA. The SMA then 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 by the SMA of the investigation results when the State deems appropriate. Notification will be made within two weeks of the State's conclusion of the investigation.

Responsibility of the Operating Agency
The operating agency has responsibility for receiving, reviewing and responding to critical incidents within one business day after discovery.

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 OA will assure immediate interventions are taken when warranted to protect the health and welfare of the recipient. The Case Manager follows up on incidents and APS referrals. When warranted, the Case Manager with approval from the AAA OARN, will put effective safeguards and interventions in place that address participant's health and welfare. 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 care plan is amended as dictated by the circumstances.

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

Oversight Responsibility of Critical Incidents/Events of the State Medicaid Agency:
The SMA reviews 100% of critical incident reports annually. During annual reviews, the SMA reviews all incident reports that relate to participants in the review sample. The SMA also reviews the DAAS annual Incident Report. If the SMA detects systemic problems either through this reporting mechanism or during the SMA's program review process, DAAS will be required 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 the plans of corrections have been achieved and are continual.

Oversight Responsibility of Critical Incidents/Events of the Operating Agency:
The operating agency has responsibility for oversight of critical incidents and events. DAAS will submit a plan of correction if a systemic problem is identified. The submitted plan is utilized to identify prevention strategies on a system wide basis and identify potential areas for quality improvement. In addition, DAAS will prepare and submit, to the SMA, an annual incident report which includes an analysis of the incident data, remediation and quality improvement activities.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

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

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The 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 80% and a confidence interval equal to 5. The SMA has established a Critical/Event Incident Notification system that requires DAAS 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 OA 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.

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

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **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 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 80% and a confidence interval equal to 5. The SMA has established a Critical/Event Incident Notification system that requires DAAS to notify the SMA of any serious incidents including the use of restrictive interventions that are reported as part of critical incident notifications.

The OA 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.

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-b-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: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

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

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The SMA monitors for the use of any 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 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 80% and a confidence interval equal to 5. The SMA has established a Critical/Event Incident Notification system that requires DAAS to notify the SMA of any serious incidents including the use of seclusion that are reported as part of critical incident notifications.

The OA also verifies that there is no use of seclusion when conducting on site visits and performing annual reviews. Any incidents involving the use of seclusion would be immediately reported to Adult Protective Services.

Case Managers have the day to day responsibility to assure that there are no incidents involving the use of seclusion.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced 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 seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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

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

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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percentage of substantiated abuse, neglect, exploitation or unexpected death incidents were required/recommended follow-up(safety plans, corrective action plans, provider sanctions etc) was completed as directed within the required time frame.(Numerator=# of substantiated incidents where follow-up/completed within the required time frame; Denominator=Total # of substantiated incidents).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver for Individuals Age 65 or Older database Case Manager Participant Records Participant Interviews

Responsible Party for	Frequency of data	Sampling Approach

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every five years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every five years

Performance Measure:
Number and percentage of abuse, neglect, exploitation and unexpected death incidents reviewed/investigated within the required time frame. (Numerator = # of substantiated abuse, neglect, exploitation or unexpected death incidents for which the investigation document is submitted within the required time frame; Denominator = Total # of substantiated incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver for Individuals Age 65 or Older database Case Manager Participant Records Participant Interviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every five years	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of suspected abuse, neglect, exploitation or unexpected death incidents referred to Adult Protective Services and/or law enforcement, as required by state law, within the required time frame. (Numerator = # of referrals made; Denominator = total # of referrals required)

Data Source (Select one):
Other
If 'Other' is selected, specify:
MDS-HC Supplement (Social Support information pg 4), Care Plan and Participant

records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and ongoing SMA: At a minimum every five years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of abuse, neglect, exploitation and unexpected death incidents reported within the required time frame specified in the critical incident standard operating procedure. (Numerator = # of reports; Denominator = Total # of reports required).

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval =+/=5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and ongoing. SMA: At a minimum every five years.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Annually SMA: At a minimum every 5 years.

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of critical incident trends where systemic intervention was implemented.(Numerator = # of trends where systemic intervention was implemented; Denominator = total # of critical incident trends

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Participant Records Participant Interviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = =+/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years.

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

Performance Measures

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

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

Performance Measure:
Number and percentage of incidents involving restrictive interventions (including restraints and seclusion) that were reported, investigated and for which follow-up was completed as directed. (Numerator = the # of incidents re reported, investigated and for which follow-up was completed; Denominator = total # of incidents involving restrictive interventions).

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Participant Records Participant Interviews

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = =+/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every 5 years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every five years

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants whose Care Plan addresses their health needs.
Numerator = Number of participants whose Care Plan addresses their health needs.
Denominator = Number of Care Plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Referrals are made to APS and/or law enforcement according to state law. Prevention strategies are developed and implemented, if warranted, when abuse, neglect and/or exploitation are reported. CM works closely with local APS workers to resolve issues. When a CM reports or becomes aware of a referral made to APS about an Aging waiver participant, the CM informs DAAS within 24 hours and documents the notification in the participant's record. DAAS has the capability to compare waiver participants' names with the APS database to determine if notification of abuse, neglect and/or exploitation of waiver participants has occurred. Upon request, DAAS has access to limited information included in the APS data base of reports that are supported by APS. DAAS reviews this information and, when warranted, provides the information to the AAA that is serving the participant for follow up. In addition, all other health and welfare needs are addressed and steps are taken to resolve concerns in a timely manner. This is documented in the participant's record.

The SMA and the OA follow the SMA Critical Incidents and Events Protocol to: 1) assure that appropriate actions have taken place when a critical incident or event occurs; and/or 2) in cases where appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard participants. Within 24 hours or on the first business day after a critical incident or event has occurred to or by a participant, a representative from the Waiver Operating Agency will notify the SMA Quality Assurance representative via email, telephone or in person. After reviewing the information provided describing the critical incident/event, the SMA determines on a case-by-case basis if the incident or event requires an investigation. In cases where further investigation is required the operating agency completes the form "Critical Incident/Event Findings OA Report to SMA". The SMA reviews the information provided by the OA and determines if any additional information or action is required. A final report is developed which contains: 1) a summary describing the incident/event based on all evidence reviewed, including evidence provided by the Medicaid Fraud Control Unit, Licensing. log notes etc. 2) Remediation Activities, describing the remediation activities that were developed and implemented to address the incident/event, including changes to care plans and systemic changes implemented by the OA and/or provider. 3) SMA Findings and Recommendations including an assessment of the OA's response to the incident/event and the identification of any issues related to reporting protocols. The SMA notifies the OA representative when the critical incident/event has been resolved.

The SMA conducts an annual review of each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The comprehensive review will include reviewing a random sample of care plans, Level of Care, MDS-HC assessments and other required documentation from each AAA to be sure all items are compliant with all current policy, rules and regulations. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DAAS and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 80% and a confidence interval equal to 5.

b. Methods for Remediation/Fixing Individual Problems

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: OA: Continuously and Ongoing SMA: At a minimum every five years

c. Timelines

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

◉ **No**

○ **Yes**

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 (1 of 3)

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

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- 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 OIS* 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 QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

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

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: Third year of waiver operation

b. System Design Changes

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

The SMA will establish a Quality Improvement Committee consisting of the SMA Quality Assurance Team, the DAAS Aging Waiver program manager, and other DAAS team members, 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.

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

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

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).*

Providers are not required to submit independently audited financial statements for review by the SMA. The SMA will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, Public Law 98-502. The State Auditor's Office is responsible for conducting the independent Single State Audit.

The Financial Audit Division is responsible for auditing all State departments, agencies and colleges and universities. Both State funds and federal grants are audited. These audits are conducted in accordance with generally accepted auditing standards, Government Auditing Standards, and the Single Audit Act to determine the reliability of financial statements, the effectiveness and adequacy of internal controls, and the degree of compliance with legal and contractual requirements.

The Performance Audit Division is responsible for performance audits of local governments and State departments, agencies, and institutions. These audits are conducted in accordance with Government Auditing Standards to determine whether agencies and programs are effective, efficient, and in compliance with laws, established best practices, and industry/professional standards.

Every year the audit focuses on different aspects and areas of government so the scope and frequency vary.

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

Sampling methodologies for financial reviews will conform with CMS requirements. Currently, representative samples with a 95% Confidence Interval, 5% Margin of Error and 50% Response Distribution will be used.

The claims/providers reviewed are determined by the individuals included in the representative sample. Applicable care plans to the review period are selected, and claims pertinent to those care plan periods are reviewed.

Reviews may be on-site or desk reviews. Several criteria may be used in determining whether an on-site review is more/less appropriate than a desk audit; there is not a set threshold. These criteria may include considerations such as: access to records; availability of State staff; nature of the audit (routine evaluation or response to an acute concern); whether the scope of the audit lends itself well to either on-site/desk audits; etc.

For routine audits, the State would intend to provide 30 days advance notice and work to ensure provider staff would be available. If responding to an acute concern, the State may prefer to make an unannounced visit, allowing a reasonable time-frame for the provision of records.

For individuals receiving self-directed services, when reviews of the FMS agencies are conducted, time sheeting and supporting documents are validated against submitted claims. For individuals receiving agency-based services, the case manager contacts the client on a monthly basis to assure waiver services are being delivered in accordance with the developed care plan.

Review results, including findings of services provided that were not included on the care plan, are communicated to providers through a draft report of findings. The provider is then given an opportunity to supply evidence to refute the findings cited. Should evidence be supplied, it is considered by the State prior to a final report being completed. If evidence is not produced, funds for claims paid for services not listed on the support plan are recovered.

When claims have been identified to have been paid in error, the State allows the provider to either pay the amount to be recouped in a lump-sum, or will withhold payment on future claims. Regardless which method is used, the claims identified are reversed and the FFP amount returned.

Any cases of suspected fraud/waste or abuse of Medicaid funds are referred to the OIG for additional investigation. Payments to providers may be suspended during this process.

Should a plan of correction be required by the provider, it is reviewed and approved prior to being implemented. During

subsequent reviews, verification of items within the plan are reviewed. Should non-compliance continue, an expanded review may be completed, or a more aggressive plan may be required with more frequent reviews. A corrective action plan would include expectations for improvement by either the next monitoring cycle, or by a date established between the SMA and provider.

The review of staffing records and qualifications will be completed during provider audits by either the SMA or the Department of Health's licensing division. The provider qualification criteria as listed in Appendix C will be reviewed for the worker in question. Any deficiencies would be communicated with the provider, allowing an opportunity to refute findings/supply additional evidence.

Beyond state and federal laws regarding the submission of independent audits, the State does not require providers to have an independent audit.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
Number and percentage of direct service claims corresponding to individuals in a representative sample which paid for services when the individual did not have an inpatient stay. N = total number of claims paid while not inpatient; D = total number of claims for individuals in the representative sample.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Claims Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*

☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *5*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	Specify: *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*

Performance Measure:
The number and percentage of claims paid with the correct unit type, HCPCS code and reimbursement rate in accordance with the reimbursement methodology specified in the waiver. N = # of claims paid with correct unit type, HCPCS code and reimbursement rate; D = total number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Care Plans Claims Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *5*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*

Performance Measure:
The number and percentage of claims, which paid for services that do not exceed the amount, frequency and duration identified on the participant's Comprehensive Care Plan. (Numerator = # of claims in compliance; Denominator = total # of claims paid)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Care Plans and Claims data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =*

		+/-5%
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every five years*	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of maximum allowable rates (MARs) for covered waiver services which are consistent with the approved rate methodology. (Numerator = total number of MARs which are consistent with the approved rate methodology; Denominator = total # of MARs for covered waiver services)

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:
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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *=+/- 5%*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percentage of care plans in which State plan services and other resources for which the individual is eligible, are exhausted prior to authorizing the same service offered through the waiver. (Numerator = # of care plans in compliance; Denominator = total # of care plans reviewed)

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Claims Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample***

		Confidence Interval = *5*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *OA: Continuously and Ongoing* *SMA: At a minimum every 5 years*

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.*

Each AAA reviews and compares monthly billings from providers with the care plans to assure that the providers have billed only for services that have been authorized and that the code(s) billed are correct. Annually, the DAAS financial auditor reviews a representative sample of billings from each of the AAA and compares the billing information with paid claims data.

The SMA conducts an annual review of the Aging waiver program for each of the five waiver years. At a minimum, one comprehensive review will be conducted during this five year cycle. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DAAS and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 80% and a confidence interval equal to 5.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States 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 a service not identified on the Comprehensive Care Plan: a recoupment of unauthorized paid claims will be required.
• When the amount of payments exceeds the amount, frequency, and/or duration identified on the Comprehensive Care Plan: a recoupment of unauthorized paid claims will be required.
• When payments are made for services based on a coding error: The coding error will be corrected by withdrawing the submission of the claim and submitting the correct code for payment.

When DAAS discovers that unauthorized claims have been paid, DAAS works with Medicaid Operations to reprocess the MMIS claims to reflect the recoupment. DAAS will notify the SMA of the recoupment.

When the SMA discovers that unauthorized claims have been paid, the recoupment of funds will proceed as follows:
1. The SMA will complete a Recoupment of Funds Form that indicates in detail, the amount of the recoupment and send it to the OA.
2. The OA will review the Recoupment of funds form and return the signed form to the SMA.
3. Upon receipt of the Recoupment of Funds Form, the SMA will submit the Recoupment of Funds Form to Medicaid Operations.
4. Medicaid Operations will reprocess the MMIS claims to reflect the recoupment.
5. Overpayments are returned to the Federal Government within 60 days of discovery.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	☒ ***Other*** *Specify:* *OA: Annually* *SMA: At a minimum every five years*

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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

Waiver rates are established by the State Medicaid Agency. Opportunity for public comment of the rates is available during the application renewal or amendment process. (Further described in the Main section of the SIP). Information about payment rates will be communicated to all interested parties through the use of provider bulletins and letters, annual public notices and annual waiver trainings. Information on rates may be requested at any time.

The State uses the following methodology to establish rates paid under the Aging Waiver program:

The following services pay the same rate as Attendant Care under the State Plan:
-Adult Companion Services
-Personal Budget Assistance

The following services pay the same rate as Personal Care under the State Plan:
-Homemaker
-Personal Attendant Services - Agency
-Personal Attendant Training Services
-Respite (Unskilled)

The following services pay the same rate as Home Health Aides under the State Plan:
-Enhanced State Plan Supportive Maintenance Home Health Aide Services

The following services pay the same rate as Private Duty Nursing under the State Plan:
-Respite (Skilled)

The following services pay the invoiced/market rate:
-Chore Service
-Community Transition Service
-Environmental Accessibility Adaptations
-Medication Reminder System
-Personal Emergency Response Systems
-Specialized Medical Equipment/Supplies/Assistive Technology
-Supplemental Meals - Home

There are caps on the 'invoiced charge' codes and also a process to evaluate the request for appropriateness including multiple bids, verification that the good/service cannot be paid through other payers (Medicare, State Plan, TPL, etc.) and that lower cost alternatives have been explored prior to paying through the waiver.

Comparable services provided in other waivers are used to establish the following rates:
-Adult Day Health – Uses FY2020 'Day Support – Individual' rate paid in Community Supports (UT.0158)
-Financial Management Services - Uses FY2020 rate paid in Community Supports (UT.0158)

Other Services:
-Respite – LTC Facility – Uses the State's Nursing Facility Weighted Average calculated at the start of Calendar Year 2020
-Transportation (non-medical) – Uses current IRS rate of $0.575 center per mile for an encounter of 26 miles
-Case Management: Pays 124% of the State's Targeted Case Management rate
-Personal Attendant Services – Participant Directed: Pays 71.4% of State Plan Personal Care Rate in accordance with BLS rates for industry wages

The current rates and methodology were based on an analysis performed in 2019 in preparation for the renewal of the waiver.

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

Waiver services providers submit claims directly to the SMA via the State Medicaid MMIS system, the SMA then pays the waiver service provider directly.

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***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.***

Select at least one:

☐ ***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.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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

DESCRIPTION OF BILLING PROCESS AND RECORDS RETENTION

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

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

Area Agencies on Aging also compare their billings against the service plans of their participants and Case Managers verify the quality and delivery of services with the participants.

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

4. The participant-directed model for the Personal Attendant Service requires the individual to use a Waiver Financial Management Agency as an integral component of the waiver service to assist with managing the employer-related financial responsibilities associated with the self-directed employee model. The Waiver Financial Management Agency is a person or organization that assists waiver participants and their representatives, when appropriate, in performing a number of employer-related tasks, without being considered the common law employer of the waiver participant's Personal Attendant(s) (PA). Tasks performed by the Waiver Financial Management Agency include documenting PA qualifications, collecting PA time records, preparing payroll for waiver participant's PA, and withholding, filing and depositing federal, state, and local employment taxes.

The participant-directed PA will complete a time sheet for work performed. The participant or their personal representative confirms the accuracy of the time sheet, signs it, and forwards it to the Waiver Financial Management Agency for processing. The Waiver Financial Management Agency files a claim for reimbursement on behalf of the Personal Attendant through the Medicaid MMIS system. Upon receipt of payment the Waiver Financial management agent completes the employer related responsibilities and forwards payment directly to the PA for the services documented on the time sheet.

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: Financial Accountability

I-3: Payment (1 of 7)

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) and how an audit trail is maintained for all state and federal

funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

- ◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Area Agencies on Aging receive payments for Case Management

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- ○ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ◉ ***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.

Area Agencies on Aging

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

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***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:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***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.***
- ○ ***This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

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

- ☐ ***Appropriation of State Tax Revenues to the State Medicaid agency***
- ☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The Division of Aging and Adult Services (DAAS) that resides within the Department of Human Services receives the appropriated State funds. DAAS draws all expenditures (claims) that had been paid by the State Medicaid Agency (SMA) monthly to verify and record. Quarterly the SMA creates an Inter-Agency Transaction (IAT) worksheet showing the total expenditures and the state match obligation that is required based on the FMAP rate. DAAS approves the transfer after verifying the amounts.

☐ ***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:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

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

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

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:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

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

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  Check each that applies:

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

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

The only waiver service furnished in a residential setting other than the personal home of the individual is Respite Care Services - LTC Facility. Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not the participant's private residence.

Appendix I: Financial Accountability

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:*

- ◉ ***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.***
- ○ ***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:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

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:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***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

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

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	9916.24	6740.45	16656.69	61121.65	6148.00	67269.65	50612.96
2	9916.24	6740.45	16656.69	61121.65	6148.00	67269.65	50612.96
3	9916.24	6740.45	16656.69	61121.65	6148.00	67269.65	50612.96
4	9916.24	6740.45	16656.69	61121.65	6148.00	67269.65	50612.96
5	9916.24	6740.45	16656.69	61121.65	6148.00	67269.65	50612.96

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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:
		Nursing Facility
Year 1	*550*	*550*
Year 2	*550*	*550*
Year 3	*550*	*550*
Year 4	*550*	*550*
Year 5	*550*	*550*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Average Length of Stay (LOS) = 289 days
Used the average annual LOS count for fiscal years 2017-19

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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 and methodology for these estimates is as follows:*

- All calculations are based off the actual amounts for FY2017-FY2019
- Unduplicated client counts were increased and the number of users was raised according to the percentage of change
- Units Per User is the average units per user for FY2017-2019 rounded to the next whole number
- Estimates may have had slight adjustments if trending data indicated that they may not be reflective of anticipated utilization
- Unduplicated counts were based on WY5 enrollment.
- Rate adjustments are subject to legislative approval and may not occur on a scheduled basis. The State will seek approval from CMS on any substantive changes (>10% based on previous guidance) and will amend estimates when they may no longer appear reflective of anticipated expenditures.

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 FY2018-2019
- The state utilizes the MMIS Categories of Service and Provider Type functionality to account for and exclude the costs of prescribed drugs from D'
- Based on recent experience and observation of D', G and G', there does not appear to be an associated trend to expenditures. For this reason, the State recommends using current experience and agrees to modify estimates if they no longer appear reflective.

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

- Used actual average nursing home cost per day for fiscal years 2018-2019 and multiplied by actual Aging Waiver LOS to get fiscal year 2021 base estimate
- Based on recent experience and observation of D', G and G', there does not appear to be an associated trend to expenditures. For this reason, the State recommends using current experience and agrees to modify estimates if they no longer appear reflective.

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

- Used actual average nursing home cost per day for fiscal years 2018-2019 and multiplied by actual Aging Waiver LOS to get fiscal year 2021 base estimate
- The cost of prescription drugs is excluded from this estimate. All pharmacy claims are assigned a specific category of service in the State's MMIS and explicitly removed from data queries used to calculate these figures.
- Based on recent experience and observation of D', G and G', there does not appear to be an associated trend to expenditures. For this reason, the State recommends using current experience and agrees to modify estimates if they no longer appear reflective.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health	
Case Management	
Homemaker	
Respite and Respite Care Services - LTC Facility	
Enhanced State Plan Supportive Maintenance Home Health Aide Services	
Financial Management Services	
Adult Companion Services	
Chore Services	
Community Living Services	
Environmental Accessibility Adaptations	
Medication Reminder Systems	
Personal Attendant Services	
Personal Budget Assistance	
Personal Emergency Response Systems Installation, Testing, and Removal	
Personal Emergency Response Systems Purchase, Rental, and Repair	
Personal Emergency Response Systems Response Center Service	
Specialized Medical Equipment/Supplies/Assistive Technology	
Supplemental Meals	
Transportation Services (Non-Medical)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg.*

Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**109189.08**
Adult Day Health	Day	26	99.00	42.42	**109189.08**	
Case Management Total:						**733243.00**
Case Management	15 minute	545	62.00	21.70	**733243.00**	
Homemaker Total:						**1119124.80**
Homemaker	Hour	372	552.00	5.45	**1119124.80**	
Respite and Respite Care Services - LTC Facility Total:						**217743.96**
Respite Care Services - LTC Facility	Day	14	18.00	194.98	**49134.96**	
Respite	Hour	37	868.00	5.25	**168609.00**	
Enhanced State Plan Supportive Maintenance Home Health Aide Services Total:						**74639.30**
Enhanced State Plan Supportive Maintenance Home Health Aide Services	Hour	10	151.00	49.43	**74639.30**	
Financial Management Services Total:						**102002.04**
Financial Management Services	Month	119	9.00	95.24	**102002.04**	
Adult Companion Services Total:						**725995.50**
Adult Companion Services	15 minute	254	555.00	5.15	**725995.50**	
Chore Services Total:						**39382.20**
Chore Services	15 minute	39	10.00	100.98	**39382.20**	
Community Living Services Total:						**616.24**
Community Living Services	Each	2	1.00	308.12	**616.24**	
Environmental Accessibility Adaptations Total:						**69701.88**
Environmental Accessibility Adaptations	Each	57	4.00	305.71	**69701.88**	
Medication Reminder Systems Total:						**23370.00**

GRAND TOTAL:	**5453934.60**
Total Estimated Unduplicated Participants:	**550**
Factor D (Divide total by number of participants):	**9916.24**
Average Length of Stay on the Waiver:	289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medication Reminder Systems	Month	41	8.00	71.25	23370.00	
Personal Attendant Services Total:						1460847.63
Personal Attendant Services	15 minute	117	2769.00	4.31	1396323.63	
Personal Attendant Services - Agency employed	Hour	3	4528.00	4.75	64524.00	
Personal Budget Assistance Total:						8600.64
Personal Budget Assistance	15 minute	16	102.00	5.27	8600.64	
Personal Emergency Response Systems Installation, Testing, and Removal Total:						6456.33
Personal Emergency Response Systems Installation, Testing, and Removal	Each	69	1.00	93.57	6456.33	
Personal Emergency Response Systems Purchase, Rental, and Repair Total:						341.00
Personal Emergency Response Systems Purchase, Rental, and Repair	Each	10	1.00	34.10	341.00	
Personal Emergency Response Systems Response Center Service Total:						73906.56
Personal Emergency Response Systems Response Center Service	Month	329	9.00	24.96	73906.56	
Specialized Medical Equipment/Supplies/Assistive Technology Total:						74499.84
Specialized Medical Equipment/Supplies/Assistive Technology	Each	223	16.00	20.88	74499.84	
Supplemental Meals Total:						416273.58
Supplemental Meals - Home	Per meal	307	186.00	7.29	416273.58	
Transportation Services (Non-Medical) Total:						198001.02
Transportation Services (Non-Medical)	one-way	138	103.00	13.93	198001.02	
				GRAND TOTAL:		5453934.60
				Total Estimated Unduplicated Participants:		550
				Factor D (Divide total by number of participants):		9916.24
				Average Length of Stay on the Waiver:		289

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to*

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**109189.08**
Adult Day Health	Day	26	99.00	42.42	**109189.08**	
Case Management Total:						**733243.00**
Case Management	15 minute	545	62.00	21.70	**733243.00**	
Homemaker Total:						**1119124.80**
Homemaker	Hour	372	552.00	5.45	**1119124.80**	
Respite and Respite Care Services - LTC Facility Total:						**217743.96**
Respite Care Services - LTC Facility	Day	14	18.00	194.98	**49134.96**	
Respite	Hour	37	868.00	5.25	**168609.00**	
Enhanced State Plan Supportive Maintenance Home Health Aide Services Total:						**74639.30**
Enhanced State Plan Supportive Maintenance Home Health Aide Services	Hour	10	151.00	49.43	**74639.30**	
Financial Management Services Total:						**102002.04**
Financial Management Services	Month	119	9.00	95.24	**102002.04**	
Adult Companion Services Total:						**725995.50**
Adult Companion Services	15 minute	254	555.00	5.15	**725995.50**	
Chore Services Total:						**39382.20**
Chore Services	Each	39	10.00	100.98	**39382.20**	
Community Living Services Total:						**616.24**
Community Living Services	Each	2	1.00	308.12	**616.24**	
Environmental Accessibility Adaptations Total:						**69701.88**
Environmental Accessibility Adaptations	Each	57	4.00	305.71	**69701.88**	
Medication Reminder Systems Total:						**23370.00**
Medication Reminder					**23370.00**	

GRAND TOTAL:	**5453934.60**
Total Estimated Unduplicated Participants:	**550**
Factor D (Divide total by number of participants):	**9916.24**
Average Length of Stay on the Waiver:	289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Systems	Month	41	8.00	71.25		
Personal Attendant Services Total:						**1460847.63**
Personal Attendant Services	Each	117	2769.00	4.31	**1396323.63**	
Personal Attendant Services - Agency employed	Hour	3	4528.00	4.75	**64524.00**	
Personal Budget Assistance Total:						**8600.64**
Personal Budget Assistance	15 minute	16	102.00	5.27	**8600.64**	
Personal Emergency Response Systems Installation, Testing, and Removal Total:						**6456.33**
Personal Emergency Response Systems Installation, Testing, and Removal	Each	69	1.00	93.57	**6456.33**	
Personal Emergency Response Systems Purchase, Rental, and Repair Total:						**341.00**
Personal Emergency Response Systems Purchase, Rental, and Repair	Each	10	1.00	34.10	**341.00**	
Personal Emergency Response Systems Response Center Service Total:						**73906.56**
Personal Emergency Response Systems Response Center Service	Month	329	9.00	24.96	**73906.56**	
Specialized Medical Equipment/Supplies/Assistive Technology Total:						**74499.84**
Specialized Medical Equipment/Supplies/Assistive Technology	Each	223	16.00	20.88	**74499.84**	
Supplemental Meals Total:						**416273.58**
Supplemental Meals - Home	Per meal	307	186.00	7.29	**416273.58**	
Transportation Services (Non-Medical) Total:						**198001.02**
Transportation Services (Non-Medical)	one-way	138	103.00	13.93	**198001.02**	
				GRAND TOTAL:		**5453934.60**
				Total Estimated Unduplicated Participants:		**550**
				Factor D (Divide total by number of participants):		**9916.24**
				Average Length of Stay on the Waiver:		289

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be*

completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**109189.08**
Adult Day Health	Day	26	99.00	42.42	**109189.08**	
Case Management Total:						**733243.00**
Case Management	15 minute	545	62.00	21.70	**733243.00**	
Homemaker Total:						**1119124.80**
Homemaker	Hour	372	552.00	5.45	**1119124.80**	
Respite and Respite Care Services - LTC Facility Total:						**217743.96**
Respite Care Services - LTC Facility	Day	14	18.00	194.98	**49134.96**	
Respite	Hour	37	868.00	5.25	**168609.00**	
Enhanced State Plan Supportive Maintenance Home Health Aide Services Total:						**74639.30**
Enhanced State Plan Supportive Maintenance Home Health Aide Services	Hour	10	151.00	49.43	**74639.30**	
Financial Management Services Total:						**102002.04**
Financial Management Services	Month	119	9.00	95.24	**102002.04**	
Adult Companion Services Total:						**725995.50**
Adult Companion Services	15 minute	254	555.00	5.15	**725995.50**	
Chore Services Total:						**39382.20**
Chore Services	Each	39	10.00	100.98	**39382.20**	
Community Living Services Total:						**616.24**
Community Living Services	Each	2	1.00	308.12	**616.24**	
Environmental Accessibility Adaptations Total:						**69701.88**
Environmental Accessibility Adaptations	Each	57	4.00	305.71	**69701.88**	
Medication Reminder Systems Total:						**23370.00**
Medication Reminder Systems	Month	41	8.00	71.25	**23370.00**	

GRAND TOTAL:	**5453934.60**
Total Estimated Unduplicated Participants:	**550**
Factor D (Divide total by number of participants):	**9916.24**
Average Length of Stay on the Waiver:	289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Attendant Services Total:						**1460847.63**
Personal Attendant Services	15 minute	117	2769.00	4.31	**1396323.63**	
Personal Attendant Services - Agency employed	Hour	3	4528.00	4.75	**64524.00**	
Personal Budget Assistance Total:						**8600.64**
Personal Budget Assistance	15 minute	16	102.00	5.27	**8600.64**	
Personal Emergency Response Systems Installation, Testing, and Removal Total:						**6456.33**
Personal Emergency Response Systems Installation, Testing, and Removal	Each	69	1.00	93.57	**6456.33**	
Personal Emergency Response Systems Purchase, Rental, and Repair Total:						**341.00**
Personal Emergency Response Systems Purchase, Rental, and Repair	Each	10	1.00	34.10	**341.00**	
Personal Emergency Response Systems Response Center Service Total:						**73906.56**
Personal Emergency Response Systems Response Center Service	Month	329	9.00	24.96	**73906.56**	
Specialized Medical Equipment/Supplies/Assistive Technology Total:						**74499.84**
Specialized Medical Equipment/Supplies/Assistive Technology	Each	223	16.00	20.88	**74499.84**	
Supplemental Meals Total:						**416273.58**
Supplemental Meals - Home	Per meal	307	186.00	7.29	**416273.58**	
Transportation Services (Non-Medical) Total:						**198001.02**
Transportation Services (Non-Medical)	one-way	138	103.00	13.93	**198001.02**	
				GRAND TOTAL:		**5453934.60**
				Total Estimated Unduplicated Participants:		**550**
				Factor D (Divide total by number of participants):		**9916.24**
				Average Length of Stay on the Waiver:		289

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Health Total:						***109189.08***
Adult Day Health	*Day*	*26*	*99.00*	*42.42*	***109189.08***	
Case Management Total:						***733243.00***
Case Management	*15 minute*	*545*	*62.00*	*21.70*	***733243.00***	
Homemaker Total:						***1119124.80***
Homemaker	*Hour*	*372*	*552.00*	*5.45*	***1119124.80***	
Respite and Respite Care Services - LTC Facility Total:						***217743.96***
Respite Care Services - LTC Facility	*Day*	*14*	*18.00*	*194.98*	***49134.96***	
Respite	*Hour*	*37*	*868.00*	*5.25*	***168609.00***	
Enhanced State Plan Supportive Maintenance Home Health Aide Services Total:						***74639.30***
Enhanced State Plan Supportive Maintenance Home Health Aide Services	*Hour*	*10*	*151.00*	*49.43*	***74639.30***	
Financial Management Services Total:						***102002.04***
Financial Management Services	*Month*	*119*	*9.00*	*95.24*	***102002.04***	
Adult Companion Services Total:						***725995.50***
Adult Companion Services	*15 minute*	*254*	*555.00*	*5.15*	***725995.50***	
Chore Services Total:						***39382.20***
Chore Services	*Each*	*39*	*10.00*	*100.98*	***39382.20***	
Community Living Services Total:						***616.24***
Community Living Services	*Each*	*2*	*1.00*	*308.12*	***616.24***	
Environmental Accessibility Adaptations Total:						***69701.88***
Environmental Accessibility Adaptations	*Each*	*57*	*4.00*	*305.71*	***69701.88***	
Medication Reminder Systems Total:						***23370.00***
Medication Reminder Systems	*Month*	*41*	*8.00*	*71.25*	***23370.00***	
Personal Attendant Services Total:						***1460847.63***

GRAND TOTAL:	***5453934.60***
Total Estimated Unduplicated Participants:	***550***
Factor D (Divide total by number of participants):	***9916.24***
Average Length of Stay on the Waiver:	*289*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Attendant Services	15 minute	117	2769.00	4.31	1396323.63	
Personal Attendant Services - Agency employed	Hour	3	4528.00	4.75	64524.00	
Personal Budget Assistance Total:						8600.64
Personal Budget Assistance	15 minute	16	102.00	5.27	8600.64	
Personal Emergency Response Systems Installation, Testing, and Removal Total:						6456.33
Personal Emergency Response Systems Installation, Testing, and Removal	Each	69	1.00	93.57	6456.33	
Personal Emergency Response Systems Purchase, Rental, and Repair Total:						341.00
Personal Emergency Response Systems Purchase, Rental, and Repair	Each	10	1.00	34.10	341.00	
Personal Emergency Response Systems Response Center Service Total:						73906.56
Personal Emergency Response Systems Response Center Service	Month	329	9.00	24.96	73906.56	
Specialized Medical Equipment/Supplies/Assistive Technology Total:						74499.84
Specialized Medical Equipment/Supplies/Assistive Technology	Each	223	16.00	20.88	74499.84	
Supplemental Meals Total:						416273.58
Supplemental Meals - Home	Per meal	307	186.00	7.29	416273.58	
Transportation Services (Non-Medical) Total:						198001.02
Transportation Services (Non-Medical)	one-way	138	103.00	13.93	198001.02	
				GRAND TOTAL:		5453934.60
				Total Estimated Unduplicated Participants:		550
				Factor D (Divide total by number of participants):		9916.24
				Average Length of Stay on the Waiver:		289

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**109189.08**
Adult Day Health	Day	26	99.00	42.42	**109189.08**	
Case Management Total:						**733243.00**
Case Management	15 minute	545	62.00	21.70	**733243.00**	
Homemaker Total:						**1119124.80**
Homemaker	Hour	372	552.00	5.45	**1119124.80**	
Respite and Respite Care Services - LTC Facility Total:						**217743.96**
Respite Care Services - LTC Facility	Day	14	18.00	194.98	**49134.96**	
Respite	Hour	37	868.00	5.25	**168609.00**	
Enhanced State Plan Supportive Maintenance Home Health Aide Services Total:						**74639.30**
Enhanced State Plan Supportive Maintenance Home Health Aide Services	Hour	10	151.00	49.43	**74639.30**	
Financial Management Services Total:						**102002.04**
Financial Management Services	Month	119	9.00	95.24	**102002.04**	
Adult Companion Services Total:						**725995.50**
Adult Companion Services	15 minute	254	555.00	5.15	**725995.50**	
Chore Services Total:						**39382.20**
Chore Services	Each	39	10.00	100.98	**39382.20**	
Community Living Services Total:						**616.24**
Community Living Services	Each	2	1.00	308.12	**616.24**	
Environmental Accessibility Adaptations Total:						**69701.88**
Environmental Accessibility Adaptations	Each	57	4.00	305.71	**69701.88**	
Medication Reminder Systems Total:						**23370.00**
Medication Reminder Systems	Month	41	8.00	71.25	**23370.00**	
Personal Attendant Services Total:						**1460847.63**
Personal Attendant Services					**1396323.63**	

GRAND TOTAL:	**5453934.60**
Total Estimated Unduplicated Participants:	**550**
Factor D (Divide total by number of participants):	**9916.24**
Average Length of Stay on the Waiver:	289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minute	117	2769.00	4.31		
Personal Attendant Services - Agency employed	Hour	3	4528.00	4.75	64524.00	
Personal Budget Assistance Total:						8600.64
Personal Budget Assistance	15 minute	16	102.00	5.27	8600.64	
Personal Emergency Response Systems Installation, Testing, and Removal Total:						6456.33
Personal Emergency Response Systems Installation, Testing, and Removal	Each	69	1.00	93.57	6456.33	
Personal Emergency Response Systems Purchase, Rental, and Repair Total:						341.00
Personal Emergency Response Systems Purchase, Rental, and Repair	Each	10	1.00	34.10	341.00	
Personal Emergency Response Systems Response Center Service Total:						73906.56
Personal Emergency Response Systems Response Center Service	Month	329	9.00	24.96	73906.56	
Specialized Medical Equipment/Supplies/Assistive Technology Total:						74499.84
Specialized Medical Equipment/Supplies/Assistive Technology	Each	223	16.00	20.88	74499.84	
Supplemental Meals Total:						416273.58
Supplemental Meals - Home	Per meal	307	186.00	7.29	416273.58	
Transportation Services (Non-Medical) Total:						198001.02
Transportation Services (Non-Medical)	one-way	138	103.00	13.93	198001.02	

GRAND TOTAL:	5453934.60
Total Estimated Unduplicated Participants:	550
Factor D (Divide total by number of participants):	9916.24
Average Length of Stay on the Waiver:	289